

Handbook of
CORRECTIONAL
PSYCHOLOGY

— *Edited by* —

ROBERT M. LINDNER, PH. D.

and

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Dedicated
to
MAN'S HUMANITY TO MAN

EDITOR'S PREFACE

Correctional psychology is a relatively new specialty. Put simply, it is a branch of applied medical art and science which properly restricts itself to the understanding and treatment of individuals under conditions of detention. Almost more than other medical specialties, it assumes a social responsibility by placing itself under an implied obligation to rehabilitate those who have proved their social incompetence and vulnerability by, in some manner and for a variety of causes, running afoul of the accepted codes and standards of the community.

The history of *correctional psychology* is difficult to write. Some would trace its origins only to the recent past and mark its beginnings with the famous McNaughten decision in England: others carry the tale into the dim reaches of antiquity, from which the magical figure of the medicine man emerges as intermediary between social pariah and the group. Be this as it may, the field may be said to have made its most rapid strides within the past quarter century. Paced by a few daring and adventuresome spirits from medicine, psychology, and sociology, this era has witnessed the heart-warming spectacle of devotion and loyalty, of the spirit of service and the acceptance of social responsibility, of biological and social scientists and practitioners. It has also seen the recognition of *correctional psychology* as a respectable member of the family of sciences by the establishment of a Forensic Section within the ranks of the American Psychiatric Association, and the Medical Correctional Association as an affiliate of the American Prison Association.

The intention of the editors in preparing this volume was to compile a practical and helpful compendium to act as a guide in correctional medical work. We have attempted to include only material which will be of practical, applicable, and immediate value. Our feeling is that the field has matured

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to the stage where this is possible; that there is a real need at this time for a volume dealing with techniques and methods for the day-to-day handling and management of medical-psychological problems encountered in our institutions of detention and custody. We hope, in other words, that this work will be a source-book to which the institutional psychiatrist, psychologist, physician, case-worker, and administrator can turn for guidance in the performance of his functions.

The editors realize that the entire field is not represented herein, that there are gaps in what is to follow. If completion is regarded as a virtue, this volume sins. While we offer no apologies for omissions, it should be pointed out that war-time exigencies, as they affect the availability of authors and the demands made upon precious time—and many other difficulties that plague editors—have interfered. We feel, however, that what is contained between the covers of this book, since it is an initial attempt to gather available knowledge about a complex field in one place, is perhaps sufficient for present needs.

The contributors to this volume are all people of wide experience and expert knowledge. They write from first-hand contact with their topics and with a broad background of study and thought. To them, the editors cannot adequately express appreciation. In the editorial work, we have striven to retain the special flavor of their literary and scientific uniqueness. We hope they will forgive our occasional tampering with a word or a comma.

It will be noted, moreover, that the titles and locations of the authors at the time they wrote their contributions have been retained for historical purposes, although many of them have moved on since the way's ending.

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CORRECTIONAL PSYCHOLOGY

INTERPRETING THE DEFENDANT TO THE COURT

LAWRENCE F. WOOLLEY, M.D.

Psychiatric advice to courts should serve two basic needs. For legal purposes the court requires an opinion as to the responsibility of the defendant at the time the offense was committed, at the time of the trial, and at the time of imposing sentence. Presumably an "insane" man is unable to commit a crime, as well as unable properly to defend himself before the law. Furthermore, it is not considered proper to execute capital punishment upon an insane person even though he was sane and guilty of a capital offense at the time of sentence, for it is considered that he is unable to understand the justice of the punishment meted out to him; hence, every report to the court must contain a clear-cut statement as to the legal responsibility of the defendant.

Psychiatric responsibility, however, should not end with this. Whether the defendant is insane or sane does not settle the issue as to what should be done with him. Not all legally responsible criminals need to be confined in penal institutions and not all of the insane need to be in the custody of mental hospitals. Modern enlightened culture requires that the handling of criminals should be aimed rather at prevention and cure than at punishment.

The psychiatrist is provided with tools for the study of behavior and the correction of deviations. No one is better qualified than he to advise the court as to the danger of repetition of the criminal act, or as to what steps should be taken to prevent recurrence.

The required understanding of the individual is gained from a review of the investigation by the probation officer if one is available; from any history that can be obtained from the defendant, his relatives and friends; and from mental, psychological and physical examinations of the defendant. A

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study made in this way serves to illuminate the social forces which have played upon him and have led to his difficulties.

The actual report should contain the body of material which comprises all of the facts obtained in the social investigation and examination procedures. This may run into many pages, and the psychiatric implications of the facts may not be clear unless they are pointed out. Hence, the body of the report should be followed by a formulation which brings together the salient facts and their interpretation in such a way that the dynamics are clear, so that the court may understand and evaluate the recommendations which follow.

It is not our purpose here to outline the detail of the necessary examination procedures. Any psychiatrist who presumes to interpret a defendant to the court should already be thoroughly familiar with these techniques. We would emphasize, however, that the formulation of the case should deal only with facts that are clearly set forth in the records of the examinations. If the reader will assume that the formulations given below contain only statements which are substantiated by facts presented in the body of the records from which they come (a statement which is true enough), he will have little trouble in understanding what we mean.

CASE 1. Chronic delinquency arising from limited intelligence, lack of training, and over-repressive home influences.

A 19 year old, single girl, accused of larceny, which offense she admits.

The social investigation revealed six previous thefts for which she had not been arrested, and for which no formal charges had been placed. There was one previous theft for which she was fined and given a suspended sentence, and two arrests for immoral conduct.

FORMULATION

A girl of borderline intelligence, from an underprivileged home, with unstable parents and an unusually repressive atmosphere due to the fanatical religious views of the family. Delinquent behavior and rebellion against authority have evidently been more frequent than the history indicates. She has been faced with problems that she was not equipped to meet, either from the standpoint of her intellectual equipment, or from the standpoint of emotional stability. She not only lacks proper school training for the best use of her capacities, but also

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Lacks a background of social experience that would fit her to live normally in the present social situation and to compete with her contemporaries on an equal basis.

Her response to these difficulties has been one of expediency, of running away, or of other evasions by lying, etc., together with some attempt to get attention and affection through contacts with the members of the opposite sex in the only way she knows how to attract them, i. e., by sexual activity.

In the light of the personality deviations of the parents and the defendant's behavior, one might be justified in considering her to be constitutionally psychopathic and delinquent. However, in the absence of evidence of parental and social protection from consequences of delinquent behavior, and in the light of the abnormal social setting in the home, one would probably be more accurate in considering this as a reactive behavior disorder in a girl of limited intelligence who is faced with problems she cannot handle.

She has reasonable insight into the nature of her predicament and its possible consequences, and is to be considered legally responsible.

RECOMMENDATIONS

The accused is in need of a consistent training and disciplinary regimen, strictly administered, but tempered with kindness. The forces at play upon her have been in operation so long that it is doubtful if a period of less than two or three years could possibly suffice to alter the pattern materially. It would not seem possible to handle this problem outside of an institution.

Hence, we would recommend that if found guilty she be sent to a Federal Reformatory for the necessary period of time for correction of the delinquent patterns.

RESULT

The defendant was sentenced to three years at the Federal Reformatory for Women, Alderson, West Virginia.

CASE 2. A psychotic, imbecilic response to the draft.

A colored male, age 37, accused of failure to report for induction as ordered by his Local Board.

FORMULATION

A mentally limited colored male of 37, whose mental age is about 8 years, with an I. Q. of about 50, a laborer with third grade education, with apparently life long use of physical complaints to cover inadequacies. Emotionally insecure, he is anxious with many fears and phobias. In periods of emotional stress he develops hallucinations

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and delusions. His mother is in a state hospital for the colored insane and suffers from a schizophrenic disorder.

By his history there is a possibility of syphilis of the central nervous system, but this, although important, is of less moment than the generally introverted personality tendencies. In addition, there is a history of head injury with symptomatic residuals suggestive of brain damage, except that this individual had similar complaints previous to the accident.

DIAGNOSIS

The diagnosis should be Schizophrenic Psychosis in a low-grade moron with possible organic components.

RESPONSIBILITY

The defendant is legally insane and cannot be held responsible for his acts.

RECOMMENDATIONS

1. Charge against the defendant should be dismissed.
2. He should be required to appear at the Induction Board for examination if this is desired by the Selective Service. He is not material that could be of any use in the military organization and would probably be rejected.
3. He should be returned home and to his job as soon as possible. He is of much more use to society there than he would be either in jail or in the Army.
4. The question of syphilis should be settled definitely. Somatic syphilis should be treated in a dispensary for that purpose. Central nervous system syphilis, if present, should be treated at once in an appropriate hospital. Spinal puncture will be necessary to settle this question. The neurological findings suggest that the central nervous system has not been invaded.
5. His illness is such that he can probably float outside of a mental hospital unless and until he becomes much worse. Many insane people, far more disorganized than he, are holding productive jobs in war industry today.

CASE 3. The hazard of accelerated maturity in adolescence. An 18 year old boy accused of assault aboard a vessel.

FORMULATION

We deal with an 18 year old boy who grew up rather rapidly, having made a fairly adequate social adjustment in his home and community, apparently well liked, industrious, thrifty and temperate in his habits, not overly bright (I. Q. probably about 90 to 95), but with enough intelligence to make a good adjustment at mechanical

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of labor pursuits. He had a good work record and apparently had success in getting along with his superiors and equals in his jobs. His schooling was limited, partly because of dislike for it (which was probably due to increasing difficulty in studying as he got older and into more advanced subjects), but partly also due to the fact that he wanted to get into the Service and do something for his country during the wartime. He had difficulty in getting his parents' consent for this, and filled up the interim by working for two different concerns, with both of which he had a good record. He would be accepted back at any time. Finally gaining his parents' consent, he joined the Merchant Marine, was sent to training school, but spent a considerable portion of his time in a hospital for treatment of his sinuses which had become infected. Following this he went aboard ship and on his first cruise away from home he developed progressively increasing homesickness. Along with this went a desire to assume what appeared to him to be the full status of manhood, so that when he reached port and was allowed shore leave, he did his best to keep up with the others in his drinking, and at times to go them one better. He was intoxicated a good part of the time while in port. On the day the offense occurred in which he struck his officer, he had been drinking excessively, having consumed about a quart of brandy prior to the incident. Not previously alcoholic, there can be no question that this amount of alcohol would affect his judgment and emotional reactions adversely and render him extremely unstable. Being relatively inexperienced in life at this level, it was probably very difficult for him to recognize what would be thought of as acceptable "ragging" between members of the crew, and he probably took too seriously defiant and bragging statements made by the others when the officers were not present. To him, afterwards, the offense did not seem nearly so serious as it did to the officers of the ship and his companions.

Following this incident he became much more sensitive regarding possible insults and slights, and was on the look-out for offenses aimed at himself. There was growing uneasiness and insecurity with emotional tensions that led to the altercation with the cook which resulted in his finally being confined aboard ship. He felt unfairly treated and discriminated against, and threatened the officers about him. From then on he was in an emotional turmoil, feeling helpless and panicky and as if he did not have anyone that he could count on to help him. Undoubtedly, he expected that his apology to the Captain would result in his being released from confinement. When this did not happen he again became abusive and angry.

The altercation with the guard at the jail appears to be in response to real or fancied insult. Again, the defendant feeling unfairly

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treated and imposed upon, and with no way of appealing for aid in protecting his "rights," became angry and assaultive.

In summary, it is felt that the defendant's behavior grew out of emotional tensions attendant upon homesickness and of feeling isolated for the first time from all the people he loved and cared about, plus the breaking down of not too mature judgment by the effects of over-indulgence in alcohol with a body not conditioned to its use. There was growing panic and concern, with feelings of isolation and of being persecuted. It is possible that these effects may have been contributed to by headaches due to sinus infection which could be severe enough to make anyone not care a great deal what happened.

The past community and work record of this individual is of sufficiently high caliber to make one feel that he is not basically criminal nor delinquent in his impulses. The nature of the offense—"physical assault"—with a view to protecting what he considered to be his "rights", is characteristic of the behavior accompanying an intoxicated state, and is often exhibited by those under the influence of alcohol.

The most serious aspect of his behavior is the repeated assaultive activity in circumstances where it could not possibly be expected to succeed, indicating either an extreme emotional instability or a profound judgment defect. It is felt by the psychiatrist that both of these factors played a role, since both would naturally result from the panic at his predicament, his feeling of disgracing and hurting his mother to whom he is devoted, and his belief that he stood alone without any protectors.

The defendant is not insane nor does it appear that he was insane at the time he committed the offense. He knows the nature of his offense and the punishment attendant upon it, although to him it appears much less serious than it must be when viewed from a social standpoint.

It is felt by the psychiatrist that this type of offense is not likely to be repeated by this individual, particularly if he abstains from the excessive use of alcohol.

RECOMMENDATIONS

It would not seem to be advisable to confine this defendant in an institution as punishment for this offense, although it is very important that he be impressed with the seriousness of the offense and the attitude of formal society toward it. We would suggest a suspended sentence to one of the Federal Reformatories, extending for a fairly long period of time.

If in the eyes of the Court it is necessary for him to be confined in an institution, then a relatively short sentence at one of the Federal

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Reformatories would probably suffice, particularly since there he would come under psychiatric guidance.

It is felt that it would not be advisable to send him to a penitentiary as the confinement and the type of associate he would meet there would tend to increase his rebellion and resentment toward society, and thereby to increase the chances of his becoming a progressively more dangerous citizen.

It is felt by the writer that a portion of the responsibility for this boy's offense falls upon society which admits to the Merchant Marine Service immature personalities of this kind who are unprepared for the separation from home and family, permitting them to become exposed to patterns of social adjustment which they are not equipped to digest, and stimulating them to indulgence in alcohol which their bodies are not conditioned to handle. Since it appears to be necessary at this time to utilize this immature manpower in this particular way, everything that can be done to conserve it socially should be tried, and it does not seem reasonable for society to proceed with the same strictness and vigor in disciplining these boys as it might have a perfect right to do were it dealing with more mature minds.

CASE 4. Unstable social adjustment in response to maternal rejection and uncertainty regarding father.

A 16 year old boy accused of stealing from the mail a War Bond Certificate, forging his aunt's name and cashing same. Because he had stolen other things from the home and the aunt felt that she had given him a fair chance, she decided to take him to the police on this occasion.

FORMULATION

A boy of sixteen whose father deserted when he was very young, and whose mother was unable to care for him at that time. He was raised by his grandmother until he was about five years of age and became very much attached to her, but when she was unable to care for him any longer, he was put in an orphanage, from which he was released on August 23, 1943, at the age of fifteen. Apparently the school record was not very good and he started to work. The work record has been rather hectic, with a good deal of absenteeism.

Since leaving the orphanage he has been subjected to several emotional shocks, the first of which was the discovery that his mother was still living when he had thought that she was dead, and that she had remarried. An attempt to live with her failed. The second serious shock was being told by his uncle that his father was not dead but had deserted his mother and was in the penitentiary at Trenton, N. J. for a crime which was not revealed. The knowledge that his father was still alive and the rejection by his mother stimulated an intense

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desire on his part to see his father, although this desire was not clearly formulated consciously.

Responses to a few intelligence tests indicate that he is of approximately dull-normal to borderline intelligence. His comprehension is rather slow but the thinking is accurate if he is given a reasonable amount of time. However, he does not reach the 12 year level on the Ball and Field test.

Responses to the Rorschach Test reveal no serious conflicts, and there are enough popular responses to indicate a tendency to social conformity. There is some indication of a certain amount of underlying anxiety, not at all incompatible with his life story and his present situation. In the limited number of responses permitted in this quick review of the cards, there are enough movement responses to indicate that his capacities correspond fairly well with his ambitions, and to suggest that there is no serious conflict in this field.

In spite of the traumatic experience of the past and the rather limited resources, the boy's attitude toward the people who surround him is essentially normal and wholesome, and his attitude toward his delinquency is basically moral, with a desire to make restitution.

DIAGNOSIS

Reactive behavior disorder. The defendant is not insane, and is legally responsible for his acts.

RECOMMENDATIONS

1. The most important consideration from the standpoint of this boy's adjustment in the future is the clearing up of his doubts concerning his parents. Whatever the facts are regarding his father and mother, their present status and whereabouts and their relationship to him in the past should be cleared up, and he should be thoroughly informed of them. This would remove a serious source of conflict and would satisfy his curiosity in the matter to a great extent.

2. If it is a fact that the father has a criminal record, the boy should be informed of the facts concerning this, and the relatives should be cautioned against the danger of identifying this boy with his father. They should not try to guide him by telling him he is following in the footsteps of his father nor do anything that would tend to make this boy feel he carries not only the burden of his own delinquency but a heritage from the past that makes it impossible for him to go straight.

3. The boy has already had many years of institutional life and requires a longer and better opportunity to adjust in society. It is felt that there would be little to be gained by sending him to a reformatory and that a much better chance of social adjustment could be attained by returning him to the community under supervision of a

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parole officer. Provisions of the parole should include a consistent effort on his part to keep at work, restitution of the money he took from his aunt, and the establishment of wholesome group contacts at the YMCA and at Church.

4. If, as seems probable, the aunt is willing to have him back in her home, the boy should be returned there as he is very fond of both his aunt and uncle and feels that they have treated him fairly. If this is not possible, it would seem advisable to place him in the Boys Home Society at 1233 Linden Avenue, Baltimore. This institution has had a long and successful experience in the community adjustment of underprivileged boys and there is a continuing and consistent program of training in responsibility and socialization.

However, it should be kept in mind that rejection by the aunt and uncle would constitute a new emotional trauma to this child, and that return to the home of his relatives would have considerable importance to him.

COMMENT:

The above sampling should serve to illustrate the type of formulation and recommendation which we feel is most useful to the court. When the statements made are substantiated by facts contained in the body of the report, the recommendations carry considerable weight and are often accepted gratefully by prosecutors, defense attorneys and the judge. We feel that it is of the utmost importance that the Formulation flows logically out of the assembled facts, and that the Recommendations are consistent with the Formulation.

However, since many communities lack facilities for the ideal handling of certain individual problems, the psychiatrist making the report must be conversant with the resources at hand in order that his recommendations can be practicable. Where resources are lacking it is permissible for the psychiatrist to state what the ideal recommendations would be. This serves an educational purpose and may at times result in an improvement of conditions. However, the court should never be left with idealistic recommendations that cannot be carried out in reality. The specific advice must always conform to the social realities or a report will be useless.

The value of a report is strengthened when the psychiatrist functions as a "friend of the court," thereby avoiding to

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a large extent the suspicion of prejudice which often makes his opinions much less effective than they should be when he examines either for the prosecution or the defense.

If the above principles are adhered to, the psychiatrist will have little difficulty in his relationship to the courts, and will find that his recommendations are very frequently accepted. This places upon him a great responsibility toward the defendant, society, the court and himself, inasmuch as he will actually determine to some extent the outcome of the lives of many criminals. If he is sufficiently aware of these responsibilities he will certainly do as complete and careful a study as he can.

THE PHILADELPHIA PROCEDURE AS USED IN THE MUNICIPAL COURT

MARNETTA E. VOGT, M.D.

Prior to 1913 there was no court in Pennsylvania dealing with the socio-legal aspects of the problems of human behavior, and in response to a demand for such a tribunal, the legislature created the Municipal Court, and gave it broad jurisdiction.

In all of its functioning, the Municipal Court is limited in its decision as to the disposition of cases by the statutes of the State of Pennsylvania. Under the law any individual of either sex who is neglected, dependent, pre-delinquent or delinquent, up to the age of 18 and beyond the control of his parents or guardians, becomes of prime importance to the Municipal Court. The primary object of the court since its inception has been to protect the young and unfit, to salvage the salvageable and to attempt as adequate a social adjustment as is possible in the complex social order of the present day.

The eleven Judges of the Court whose responsibility it is for making decisions as to the disposition of cases, primarily approach the individual involved from a humanitarian viewpoint, influenced by the organized medical, psychiatric, psychologic, sociologic and social work aspects, which have developed hand in hand over the years of the Court's existence.

Since the mores and social standards of our times have changed, the necessity for varying the approach and solution of the problems involved has changed to a degree, but nevertheless the fundamental basic principles of good social conduct have remained unchanged. Flexibility has been and probably will remain the cardinal watchword of the judges, accompanied by a sympathetic insight, plus the recognition of the human variabilities of each individual.

Misdemeanors are the commonest form of antisocial behavior seen in the Court, and while felonies can be disposed

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of by the judges, the close coordination in the functioning of the court and the District Attorney's Office frequently moves the jurisdiction to a higher court, particularly if involved with one or more older persons.

Even though the problems of a metropolitan society are acutely realized by the forward looking citizens, the same developmental, administrative techniques hold true for the smaller communities as well.

EXCLUSIVE JURISDICTION OF THE MUNICIPAL COURT

The municipal court has jurisdiction in a wide variety of cases. Primarily, of course, in juveniles, this includes dependent, delinquent, neglected, mentally defective, and physically handicapped children. It also includes adults contributing to the delinquency, neglect, or dependency of minors. Another function is to investigate formal complaints of an individual or an organization relating to juvenile delinquency and to act on petitions for placement.

The domestic relations division is concerned directly with the desertion or non-support of wives, dependents, parents, and the custody of children. A labor bureau secures employment records, verifies wages, incomes, property holdings, etc., and aids in securing employment for men and women.

The men's and women's misdemeanor division is concerned with vagrancy or disorderly children from 18 to 21 years of age; adults charged with being disorderly; vagrants; alcoholics; and other offenses not subject to trial by jury. In addition, it has primary jurisdiction over prostitutes and adoption proceedings; in the former instance it serves without fee as a legal, moral, and hygienic investigative body.

CONCURRENT JURISDICTION OF THE MUNICIPAL COURT

The civil division at law and in equity considers claims up to \$2,500, all civil appeals from magistrates, and civil cases transferred to it by any Court of Common Pleas of Philadelphia County. The conciliation, Small Claims, and Legal division gives legal advice and assistance to residents of Philadelphia financially unable to employ an attorney, and serves

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them by collecting small sums and wages, as well as by lending assistance to persons embarrassed by levies or attachments.

Criminal actions, except in crimes of the gravest nature, can be assigned to the Criminal Actions Division and except for fornication and bastardy involving unmarried mothers this is at the discretion of the District Attorney, who may choose the Court of Quarter Session. Both men's and women's divisions make pre-sentence investigations of convicted men and women, supervise inmates probationed and paroled from the County Prison, and collect fines, costs, and reparation money in cases of stolen or damaged property. In addition, the Woman's Division gives special attention to unmarried mothers, investigates and serves warrants for arrest of alleged fathers, and when paternity is established, an order may be made on the father for support of the child until it reaches the age of 18. The father is also responsible for hospital expenses, and in the event of death of the child, for its funeral expenses. Complaints in fornication and bastardy cases must be made within two years of the date of conception; while failure to support the child must be made within two years of the time when support was last paid by the putative father.

REASONS FOR REFERRAL TO COURT

Both boys and girls are most commonly accused of the following:

- Runaway.
- Incorrigible.
- Disorderly Conduct.
- Larceny.
- Shoplifting.

In addition to the above, the girls were accused of Prostitution and Soliciting. The boys, in addition to the main headings, were accused of:

- Breaking and Entering—these cases constituted the largest number in this group.
- Malicious Mischief and Property Destruction.
- Automobile Stealing.
- Robbery and Holdup.

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The totals evidence again that the majority of the boy's offenses were against property, in contradistinction to the girl's offenses against the person.

Runaway and Incurrible Cases: Here an attempt is made to adjust the cases outside of the Courtroom, if first offenders, and both boys and girls are released to their parents or guardians if feasible. The next step, if they are persistent offenders, is to place them on probation or commit them to an institution for training. The place of commitment depends on their race, religion, age, sex, and whether or not they have normal mentality or are defective.

Disorderly Conduct:

Discharged.

Probation.

Commitment.

Larceny:

Probation with Restitution.

Commitment.

Malicious Mischief with Property Destruction:

Probation with Restitution.

Commitment.

Automobile Stealing:

Probation.

Commitment.

Robbery and Holdup:

Probation.

Commitment.

Homicide: Few cases of this type are encountered, but when they are, the Municipal Court Judge sits as a committing Magistrate, holds the individual for action by the Coroner, and probable trial by jury in a higher court.

Acute Alcoholism: Is encountered in both sexes and the cases are usually discharged or placed on probation.

Chronic Alcoholism: Is seldom seen in the very young,

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but too frequently encountered in the older men and women in the Misdemeanants Division. Here the cases are:

Discharged

Placed on — Probation.

Referred to — Alcoholics Anonymous.

Referred to — Neuropsychiatric Clinics.

Committed to — House of Correction, two to six months.

Committed to — Psychopathic Ward of the Philadelphia General Hospital.

Since the pathological drinker is almost completely unable to face the realities of his or her existence, it is almost a hopeless proposition, from a psychological standpoint, to eliminate the stresses and strains from his or her life. Certainly Alcoholics Anonymous is a valuable adjunct to any treatment of the alcoholic patient, for the following reasons:

1. They all are or have been alcoholics.
2. They help other alcoholics. Promise to make him useful. Go out with him when drinking. Take him home when drinking. Will answer a call any time of the day or night.

Epilepsy: This condition is divided into Petit Mal or Grand Mal seizures. Detailed histories are obtained when possible, particularly in reference to birth injuries. Too much emphasis cannot be stressed regarding the value of the Electroencephalogram. Since this requires a specialized technique, the test is usually done at the Graduate or the Philadelphia General Hospital. While in custody at the Court, seizures are controlled by Phenobarbital or Dilantin. Since most epileptics, particularly the girls, feel socially ostracized, an attempt is made to plan for their future existence. Consequently, mild cases are turned back to their families with special instructions and referred to an Epileptic Out-Patient Clinic. Supervised outdoor and farm work, with as little emotional pressure as possible, is occasionally successful. Unfortunately, an associated mental deficiency is too often encountered in conjunction with the epilepsy. If prolonged training is indicated, the

Oakburne Epileptic Colony is used, or the recently established State Colony for Epileptics at Selinsgrove.

Prostitution: Prostitution, per se, is practiced for one of two reasons, either for money or for pleasure. Being rooted in one of the deepest of fundamental human urges, it never has been and probably never will be legislated out of existence. There has been a surprising downward trend in the number of "old time" prostitutes arrested in the past three to four years. More intelligent policing is probably not the answer, but a marked drifting away from their old habitats. The girls we see now in the Municipal Court are much younger and practice prostitution mainly for pleasure. The widespread attraction for uniforms of any sort, their desire for pleasure and the supposed social approbation in being termed a "Victory Girl", have all been conducive to the relaxation of their moral standards. The majority of these girls function either in the subnormal or moron group, are unstable, wanderers, attracted irresistibly to bright lights or all night movies, and see no reason for developing any anchorage. Casual pick-ups and promiscuity are the normal way of life for many of them, at present. Unfortunately, these acts of delinquent sex behavior are not limited to a single social stratum but penetrate deeply into the whole fabric of society. It is in this unstable, adolescent, war-tensioned group that venereal disease has assumed its most alarming and dangerous aspect.

PHYSICAL EXAMINATIONS

Cases are referred to the Municipal Court by parents, guardian, religious organizations, the Board of Education, various social agencies, the Police Department, and the Department of Public Welfare.

No matter what the age or sex of the individual a physical examination is done. The total number of such examinations made in 1943 in all divisions of the Court was 13,628.

Cases listed as "friendly service" or "complaints" can be referred to the various hospitals in the districts where they reside, for any medical and surgical attention necessary. The

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interacting nursing staff and probation departments check on whether or not the referrals are carried out as recommended.

Any individual in custody or under arrest is referred to the Philadelphia General Hospital for medical and surgical care. In these cases a court detainer accompanies the person to the hospital, and when released from the hospital, he or she is returned to the place of detention from which he was originally sent.

Because of the Public Health aspect of Venereal Disease, there is an unusually close correlation between the Court, the Venereal Disease Division of the Department of Public Health, and the United States Public Health Service. The decision as to whether any case of syphilis is an infectious one, and thus a menace to public health, is made by the Medical Department. All infectious cases are incarcerated for treatment, and when rendered non-infectious are released to the community on medical probation. The interaction of the Court and the Venereal Disease Division of the Department of Health thus protects the individual, the family and the community as a whole.

While on medical probation the time and place of treatment is adequately checked weekly by a representative of the Department of Public Health. If medical probation is violated to the extent that the community is endangered, the individual is returned to court, and reincarcerated until all danger is past.

Cases of gonorrhea are always incarcerated and never placed on medical probation until released from the institution where the treatments have been given. In any questionable cases of gonorrhea, the usual practice is to hold the individual in one or two of the Houses of Detention operated by the Court. During this period of detention three sets of cultures for gonorrhea are taken, and the person involved is not released to the community unless negative cultures are obtained.

No distinction is made in the type of physical examination or mental examinations in cases referred to the Municipal Court by the higher local courts or the Federal courts. Since these cases are usually prisoners, copies of the examinations

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with suggestions and recommendations for the handling of such cases, if physically or mentally ill, are submitted to the sitting Judges of the State or Federal courts who originally referred the cases.

DENTAL DEPARTMENT

In 1943, the number of treatments given was 10,801.

MENTAL EXAMINATIONS

In making psychological examinations, the Municipal Court is equipped to use the following tests:

Revised Standard—Binet.

Wechsler—Bellevue.

Minnesota Multiphasic Personality.

Rorschach.

The youngest child examined was one of six months of age. Of these very young cases, the Vineland, Gesell and Kuhlman tests are used. If possible, these tests are checked at a later date. For blind children the verbal portions of the Binet and Wechsler tests are preferred.

The most valuable information in deductions is undoubtedly obtained from the correlation of the reports of the Binet, Wechsler, Minnesota and Rorschach tests. While not infallible, the picture then becomes as clear as it is humanly possible to indicate.

Due to the pressure of the number of cases seen in the Neuropsychiatric Department, it is not always possible to give as comparable a number of psychological tests as psychiatric examinations. In uncomplicated cases, the psychiatrist makes the decision as to which cases shall be tested. In view of the fact that the majority of cases show some defect or abnormality, most cases are tested.

The preferred manner of seeing any case, dependent, defective, or delinquent, is to have a complete history of the individual. This is accomplished before being seen by the psychiatrist, by the combined efforts of the person making the complaint and the Probation Officer assigned to the case.

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It is also preferable to have the physical examination completed, and this is usually done, except for the laboratory reports which can be received in twenty-four to forty-eight hours. The home investigation is done either before or after the medical examination by the Probation Officer, always keeping in mind the conflicts which possibly originated in the home.

The sympathetic approach by the psychiatrist to all cases is of greatest importance, as well as the recognition of the psychosomatic problems inherent in the great majority of cases. Psychotherapy in the form of psychiatric counselling and guidance is frequently used for the benefit of the individual involved and his guardians.

When cases are definitely psychotic or need further study to determine the extent of the psychosis, they are committed to the Psychopathic Ward of the Philadelphia General Hospital. This applies to Municipal Court cases, other local courts and federal cases. After approximately three weeks study, a staff conference is held at Philadelphia General Hospital and, if necessary, psychotic cases within the jurisdiction of Philadelphia County are committed to Philadelphia State Hospital. Cases residing outside the county are transferred to their own counties, and those residing outside Pennsylvania are transferred to their respective States. Federal cases are disposed of finally by the Federal authorities.

When all the reports of the examinations are complete, recommendations for handling each case as an individual one are then referred to the Probation Department or submitted to the judge for final disposition in court. It is rare indeed when any of the Judges will dispose of a case without all the correlated information at hand. The total number of mental examinations made in 1943 in all divisions of the Court was 11,650. The Court of Quarter Sessions referred eight cases for examination and the Federal Court referred forty-eight cases for examination.

WHAT IS DELINQUENCY?

Where does normal mischief end and delinquency begin

in childhood and adolescence? I confess to not knowing where the line of demarcation is or where it should be. Certainly, definitions of certain social problems, based on a nation-wide scale, are a necessity if our approach to the problems of adolescence and childhood is to gain in value and significance for the future benefit of the nation.

It is a truism that crimes of all sorts, even petty ones, can be divided into two groups:

1. Crimes against Society.
2. Crimes against the Person.

By far the large majority of cases seen in the Municipal Court comprise offenses against Society. In 1944, for the ten months ending October 31st, 7,134 boys and girls under 18 came under the jurisdiction of the Municipal Court. Of this group:

- 63% were discharged.
- 20% placed on probation.
- 11% committed to institutions for delinquents.
- 5% were committed to other institutions.
- 0.6% were referred to other courts for disposition.

One cannot evade the fact that each case coming before the court is in some degree, if only a minor one, a human representative of individual and social pathology. Young minds persistently grasp for freedom in all their actions, not being able to recognize the incompatibility of their desires and their adjustment to society. Consequently, their adolescent instabilities assume the form of social misbehavior as well as sexual misbehavior. Parents contribute to these same instabilities by refusing to be realistic about their children and by setting too high standards for them to live up to. Contrariwise, some parents have too little interest in their children and cannot escape their share of the blame in producing social misfits. The problems involved ramify deeply into all levels of our cultural conflicts, necessitating a constant education and reeducation of the individual and group alike. Psychic damage can be caused by innumerable things, and the damage begins at

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any threat of insecurity, no matter how young the individual. The unfortunate biologic, sociologic and economic backgrounds of the girls and boys brought before any court contribute to a large degree to their socially unacceptable behavior.

I have been impressed again and again, and over a period of years, by the demoralizing effect on both boys and girls when they discover that they have been born out of wedlock. Consider the thousands of adolescents who discovered the word "illegitimate" on their birth certificates in the past five years alone. Confusion, insecurity, conflicts and damage become so deep-seated that I personally have never seen an adolescent survive the episode without a desire to "lash out" against society as a whole. Certainly an effort should be made by each State and the Nation to protect the vulnerable and unstable adolescent from suffering from an act for which he or she is not culpable.

Too much recognition cannot be given the close relationship between unconventional sex activity, truancy and other forms of delinquent behavior. Energy of all kinds, including sex energy, must be channeled in the proper direction or explode.

Delinquent behavior drops in depressions, fostered by closer cohesion in the family units, and rises in varying degrees when economic conditions improve. In time of war, violence is approved and the impact of heightened tensions in the home and the community releases the unconformed predatory instincts of the young.

Regardless of the necessity of distinguishing between normal, defective and psychopathic delinquents, each group needs to develop a purpose and a philosophy of life for development, and the ratio of good or poor future social adjustment depends not only on the parents, but also on whether or not the community as a whole is indifferent, antagonistic or friendly to the problems presented.

Approximately 60 to 66 percent of young people coming before the court have been found to function in the moron group by our standards of measurement and diagnosis. As a

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rule, they are all too easily influenced by stronger characters than their own, are unstable and casual in their relationships, and see no harm in promiscuity. They are persistent runaways and it is difficult for them to acquire any roots or develop any feeling for anchorage. They are unable to supervise their children, and contribute in a great degree to the cases of Neglect and Desertion.

The personality patterns of the defective child persist through adulthood, with the tendencies toward delinquent and criminal behavior becoming more fixed, unless their energies can be put to constructive use. Undoubtedly much of the world's work is done by the subnormal group, and their ability or inability to adjust to their own social orbit has been influenced since the industrial revolution by the work habits having been changed from an individualistic to a collective basis. The recognition of the broad sociological changes taking place should stimulate people as a whole in recognizing the impact of these changes and in planning for their incorporation into our present and future social order.

The same defects, instabilities, etc., described above contribute in a large degree to recidivism.

Since it is necessary to distinguish between the normal and the psychopathic delinquent, the most persistent offender in this direction is the Constitutional Psychopathic Inferior. This type does not fit into any paragraphs of the law, for he learns nothing from past experience, usually has normal or near normal mentality, and punishment penetrates only to his conscious mind, never his unconscious mind.

For the future, it would seem that the most effective way of combating antisocial behavior will be by the coordinated efforts of all groups interested and trained in the social sciences.

COORDINATION OF SOCIAL AGENCIES

The Municipal Court is fortunate in its contacts and close cooperation with the:

Board of Education.

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Department of Public Welfare.

Catholic Children Bureau.

Jewish Welfare Society.

Colored Children Bureau.

Lutheran Bureau.

Department of Public Assistance.

Social agencies not only in the City of Philadelphia, but the adjoining Counties and States are utilized.

Before commitment to any institution, depending, of course, on the nature of the offense, an attempt is made to place children in their own homes, boarding foster homes, or work foster homes. When this plan is not feasible, institutional care must be considered.

CLASSIFICATION OF THE CRIMINOTIC INDIVIDUAL

ARTHUR N. FOXE, M.D.

Classification is about as useful as a time-table or a road map: indeed, these also are forms of classification. A time-table is not a vacation or a trip but a means to both of these. Similarly, classification, although dependent on a thorough and detailed collection of sufficient data, is but a step in understanding the criminotic individual, especially where one is compelled to handle large numbers of such individuals. Classification should be a helpful instrument and not a compulsive method of labelling. One may hope that prisons some day may not be necessary, and one may feel that they are anomalies; nonetheless, like sanitarium, they serve a current purpose. The newcomer to the field of work in criminology will find classifications only helpful as summations of the previous experience of others. They should spare the investigators years of fact-unearthing, and should stand as a symbol to the layman that there already is a body of knowledge, not merely theoretical, but practical and based upon experience. The novice need no longer feel helpless. Just as it would be difficult to use penicillin wisely if one could not make a diagnosis, so it would be very difficult to prepare future research, study, and care without knowing the varieties with which one deals.

Classification developed out of prison work. In the past, the classification clinic has been largely a recommending unit. Classification is based on information from many sources, as in all good case work. The purposes of classification have been to assist in the choice of individuals to be transferred for rehabilitative or administrative need, to help understand the relation of the problems involved to schooling, employment, and vocational training, to assist in the selection of individuals for treatment and research, to assist in giving aid and advice

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when requested, and to assist in the work of the courts, parole boards, and clemency boards.

Classifications are of many kinds. Those deemed most practical, and to be considered here, are administrative, psychiatric, maturational (partially causal), and psychoanalytical (for guidance in therapy). Those presented are not to be conceived of as permanent, and they are but the improvement of previous systems.

Administrative Classification: In no way will the worker in the field of criminology ease his headway better than by knowing what indications are used by prison administrators in the practical handling of those confined to prison. It is not rare to find the trained psychologist or psychiatrist ridiculed because of easily avoided and elementary errors. Prison administrators are most interested in administration but have not codified their knowledge; they generally are all-practical and do not take a hand in writing.

Any administrative classification can only be a rough guide. There are so many problems to be considered in each case that experience must be the supplement to this guide. An individual is placed in one of these categories to give a clue, to one quickly glancing at it, as to what may be the main administrative problem. It does not mean that the individual is entirely foresaken to this unit. Thus, perhaps, a majority of men in prison could profit by education; this is so obvious that there is no need to include any but special types in the *education* group. Similarly a majority of inmates could be assisted by personality and character guidance by psychologist or psychiatrist, but only special cases are included in the *psychiatric* group. The same applies to other groups. The term "Colony Choice," previously used in classification, has not taken hold because the connotation of the term deviates too much from actual practice. Such a former term as "Restricted" is less definite than the terms used herein. The terms "Prolonged" and "Temporary," heretofore used, are too indefinite and static and may easily be discarded by adding to

every *intramural* classification the approximate date at which the subject may be considered for extramural employment. Administrative classifications are best when simple and without too much subgrouping. It is better to reserve for the officer in the particular department the problem of the multitude of possible subclassifications, and not to include this in the general administrative classification.

1. *Intramural*: (a) Those with long sentences. An inmate is rarely permitted outside the prison walls if he has more than a year or two to serve before eligibility for parole. Exceptions are where all conditions indicate the man may be trusted and that he already has served a fairly long period of years in prison—years that he would hesitate to sacrifice by an attempted escape.

(b) Those with warrants held against them.

(c) "Lifers" — those serving natural life sentences or twenty years to life. One must weigh a man's maximum sentence and how much he might gain by escape.

(d) Certain sex offenders who probably will not be released upon first appearance for parole.

(e) Those individuals who have shown flight or escape tendencies in the past, unless these are part of youth long past. These flight tendencies are indicated by records of previous escapes, desertion from Army, Navy, etc. Nomadism with no real home; this often is indicated by location of family in some distant State. The lure of relatives at a great distance may increase the tendency to escape.

(f) Individuals who have no family, who are hostile to their families, or who have no bonds to their families, are always doubtful cases for extramural placement.

(g) Very unstable, very assaultive and impulsive types. Very unstable, immature types.

(h) The infirm.

(i) Those with long records, with rare exceptions.

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(j) Agitators or those known to have incited to riot.

(k) Very often men held by the Parole Board to serve additional time.

At the end of each intramural classification the approximate year for reconsideration for extramural employment should be indicated.

2. *Extramural*: (a) Occasional accidental offender who has served at least one-half his minimum sentence in prison, whose remaining minimum is not over three years and whose maximum is not over ten years. (There are rare exceptions to this rule, nor is it necessary to follow it with absolute mathematical accuracy; an approximation is sufficient.)

(b) Matured offenders where the difference between minimum and maximum sentence is not over three years.

(c) Parole violators who have served at least half their lost time after return, and who have no more than three years to serve to complete maximum. Does not apply to new sentence.

(d) Middle-aged inmates with good family bonds determined by investigation and active interest during incarceration. Many have served considerable time and have reached a stabilization period.

(e) Relatively stable individuals who have shown their capability of accepting responsibilities in prison.

(f) Stable, high-grade feeble-minded types.

Extramural inmates may be divided into three types as given below. These are only general guides and one factor may outweigh others. Thus, where personality, family bonds, etc. are exceptionally good, the matter of a year or two may not be so important.

(A) *Little Supervision*: Inmates who may be used extramurally with every confidence that they will not escape and will abide by prison rules. This is determined by a careful

examination of any possible inducements to escape, etc., etc., as noted above, the balance of time served and time still to be served, the general emotional balance and make-up of the inmate, and his particular usefulness in some outside position.

(B) *Ordinary Supervision*: Inmates who by consideration of all of the above factors would not be satisfactory with little supervision but who could very well maintain their equilibrium under the guiding eye of some officer. These inmates would return within the wall for purposes of eating and sleeping.

(C) *Close Supervision*: Inmates who are needed on construction details but in whom, all factors considered, there may be a small element of doubt. These men are constantly under surveillance of armed guards.

(D) *Nonmural*: Inmates for a prison without walls. Such inmates would be chosen with the purpose of a nonmural prison in view, to achieve an ideal environment for those types most reclaimable. Such inmates would have to have the requirements at least of those under "ordinary supervision."

(E) *Psychiatric*: Any inmate showing or having shown potential psychotic or actual psychotic conditions. Such inmates must be under varying degrees of surveillance by the psychiatrist and officer immediately in charge of inmates.

Any inmate who because of chronic mental abnormality may not be usefully employed or only limitedly employed.

(F) *Educational*: Those in whom the outstanding problem is one of educational lack.

(G) *Hospital*: All those partly in capacitated and requiring prolonged care or observation by the physician. In these the medical problem must be the outstanding one.

(H) *Mental Defective*: Inmates who should be transferred to an institution for mental defectives.

(I) *Insane*: Inmates who should be transferred to a Hospital for the insane.

Psychiatric Classification: Those trained in the field of psychiatry and psychology and have examined the literature,

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know the value of accepted terminologies in conveying a large mass of information in a few words. To try to convey the meaning of these terms to those uninformed and without academic and clinical backgrounds usually is a thankless task; for some reason one is supposed to be able to do this although an engineer hardly could interpret to the layman many of the formulae of higher mathematics. With a psychiatric classification, trained men find it easy to communicate with one another in their description of individuals. Hence the value of what is called psychiatric classification.

PSYCHIATRIC CLASSIFICATION

A—Normal

B—Feebleminded

(a) I. Q. to —

(b) I. Q. — and above.

C—Neuropathic (not insane but subject to mental abnormalities)

(a) Psychopathic personality

(b) Epileptic

(c) Postencephalitic personality

(d) Alcoholic

(e) Drug addict

(f) Neurotic (includes traumatic neurosis)

(g) Other brain, nervous or endocrine abnormalities without psychosis — to be specified

D—Character group

(a) Immature character (includes adolescent character and psychosexual immaturity)

(b) Inadequate character (includes ego inferior or constitutional inferior types)

(c) Hypomanic character (extrovert)

(d) Schizoid character (introvert)

(e) Pervert character (homosexually active or perversions)

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- (f) Nomadic character
- (g) Depressive character (hypochondriacal)
- (h) Litigious character
- (i) Paranoid character
- (j) Primitive character
- (k) Impulsive character
- (l) Pathological liar
- (m) Criminally gregarious character (outspoken "gangster")
- (n) Antisocial character

E—Potentially psychotic

- (a) Recovered from psychosis
- (b) Psychosis in remission
- (c) Physical symptoms of incipient psychosis

F—No mental disease

Maturational Classification: For a quick and true grasp of the dynamic currents of any criminotic individual, there is nothing so valuable as a consideration of maturational problems, and hence this form of classification. The fact that most inmates of the prison system are young in years accentuates the need for the study of individual maturational problems. Such a classification is as follows:

1—The Developmental Criminotic (or Criminal)

As an example—The youth who steals a car, then commits a burglary, then a robbery and settles down at about the age of thirty.

2—The Repetitive Criminotic

The repetitive burglar, forger, pickpocket, or sex criminal whose activities often continue well into middle age.

3—The Occasional Criminotic

A—Situational I Economic Problems

II Crises of life — Engagement, marriage, fatherhood, infidelity of marital partner, frustration in love,

CLASSIFICATION OF THE CRIMINOTIC INDIVIDUAL

serious sickness in family, an insult or hostile act.

- | | |
|------------|---|
| B—Physical | <p>I Venereal and other diseases or injuries which are blows to pride, vanity or capacity.</p> <p>II Rare alcoholic bout.</p> <p>III Curable or incurable mental disease, syphilis, sleeping sickness, etc.</p> |
|------------|---|

Psychoanalytic Classification: Lastly, in the selection of cases for treatment and research, there is considerable usefulness in knowing the depth to which a problem may extend; the labors in effecting a change necessarily become less discouraging and in many instances more rewarding. Whereas maturational classification tends to look forward, the analytic looks back. To utilize this classification one must be acquainted with the psychoanalytic concept of trauma and fixation in infancy; for instance, the effects of unduly delayed weaning or neglect in appropriate training of bowel and urinary functions in infancy and the tendency of such influences to contribute to the determination of later character formation. The meaning of the term *primal* criminosiis is apparent from the table. By *criminosiis in action* is meant the state of an individual who commits what society considers to be an active crime, that is, a physical, forceful, active crime upon person or property; society is rather severe in such instances. By *criminosiis in reaction* is meant the state of an individual where the degree rather than the form of the act is merely disapproved of by society. Thus in robbery, the use of a gun and the force are both condemned, hence criminosiis in action. In forgery, the pen is sanctioned but not its extreme and improper use; hence criminosiis in reaction. The reactive type of criminotic usually has had a better education and greater personal opportunities in childhood and adult life. Society deals less harshly with this latter type of crime. It will be noted that the terms used in this last classification are the terms used by the legal profession to describe the individual by his act. The legal termi-

nology, however, has a moral connotation. An attempt is made to avoid part of this, at least, by the term *criminosis* (comparable to the terms neurosis and psychosis) rather than the terms criminal and delinquent.

TABULATION OF THE CRIMINOSES

Stage of Fixation	Primal Criminosos	Criminosos in Action		Criminosos in Reaction		Criminosos in Action (Minor)
		(Criminosos in Perversion)			(Border Criminosos)	
Early Oral			Larceny of cash Unlawful entry			Vagrancy
	Patricide Matricide Fratricide		Assault and Murder	Forgery		Disorderly conduct
Late Oral		Sodomy (oral)	Burglary	Embezzling		Pickpocketing
			Intermediate types of Burglary and Robbery	Intermediate types as Extortion	Receiving	
Late Anal		Sodomy (anal)	Robbery (with gun)	Swindling		
		Indecent exposure	Arson			
Urethral and Phallic	Incest	Manipulation	Rape	Bigamy		

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As a last word, an aid of no small value in working with the criminotic individual and his keepers, is to examine thoroughly, and have as a reference work, some compendium (see bibliography) of the penal law and code of criminal procedure; the penal law, in fact, is the first classification which society has built up through many centuries. An earnest and careful determination of the four classifications outlined above for any criminotic individual will leave any serious worker with an assurance that he knows what he is about in a given case, and will serve him well as a platform for further steps in research and therapy.

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THE CLASSIFICATION CLINIC IN A CORRECTIONAL INSTITUTION

RALPH BRANCALE, M.D.

Although psychiatric concepts are diffusively permeated throughout penal thinking, the application of psychiatry to correctional work has followed a slow and irregular course. The ultimate success of institutional psychiatry will depend on the extent that traditional prejudices and resistances are dissipated and the manner in which it is able to reorient itself to the many conditions peculiar to prison and reformatory organizations. It is common knowledge that a successful psychiatric program is measured by the way it adapts itself to the many extraordinary situations found within correctional institutions.

The classification clinic with its psychiatrist, psychologist, and social worker, is the functional unit of a psychiatric program. Collaterally and intimately associated with the clinic are usually to be found the physician, disciplinary officers, chaplains, and educational personnel. The coordinating activity of the clinical work has largely been in the hands of the psychiatrist. Not infrequently, however, this role has been assigned to another member of the clinical staff.

The clinic strives to obtain the complete knowledge of the mental workings of the inmate and to form a line of treatment based on this knowledge, one which will effectively deal with the many problems that such offenders present. From its clinical studies must emerge that body of information which will enable a psychiatrist and his colleagues to deal with the needs and wants of individual inmates, and to assist them to readjust to useful social living. Such information must include knowledge of all factors, extrinsic and intrinsic, congenital and acquired, that play a part in shaping the total personality and its ways of functioning.

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The clinic has a diagnostic and therapeutic function. An adequate classification service usually covers the following kinds of activities:

- (1) A complete and correct evaluation of the personality of prisoners, including medical, psychiatric, and psychological studies.
- (2) The utilization of this knowledge in planning programs of treatment in terms of individual personalities, capacities and interests by:
 - (a) Working with administrative officials in the scientific and practical assignment of inmates, taking into account both individual and administrative needs.
 - (b) Participating in the treatment and management of disciplinary cases.
 - (c) Dealing with the problems of the mentally sick . . . the prevention of mental^a breakdowns, the commitment of the insane and the mentally defective to proper institutions and, in addition, the preparation of recommendations for the transfer of certain inmates to other institutions for specialized treatment, *i.e.*, drug addicts, tuberculars, syphilitics.
 - (d) The application of direct mental treatment for those who are ready to benefit from it.

Administrative Classification: About 1930, when psychiatric concepts were relatively new in prison practice, classification procedures were thought of and described in terms of custodial needs and safeguards. An example of this emphasis was the administrative classification used in the State of New York. This system differentiated prisoners primarily in terms of restrictions, varying from the "privileged trusty", described as the "colony" type, to the "incurable" inmate, classified as the "prolonged intractable" type. Work and housing assignments in those days were generally made in the

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light of the degree of restrictions indicated in this classification procedure. This was a flexible type of classification, in that inmates moved from one group to another as their prison sentences became shorter.

ADMINISTRATIVE CLASSIFICATION

- I. *Colony Group*
 - Type 1 Extensive privilege
 - Type 2 Limited privilege
- II. *Restricted Group*
 - Temporary restricted
 - Prolonged tractable
 - Prolonged intractable
- III. *Psychiatric Group*
 - Ambulatory
- IV. *Hospital Group*
- V. *Defective Delinquent*
- VI. *Insane*

As the psychiatric viewpoint began to infiltrate in the thinking and management of correctional institutions, this administrative classification fell into disuse. Experience showed that it practically duplicated psychiatric findings in too many instances. The "colony" inmates were usually the normal; the "intractable" groups were usually the psychopathic. Its impracticability in alleviating administrative problems was made increasingly apparent as chief custodial officers became aware of the much greater values inherent in the psychiatric classifications.

Psychiatric Classification: The utilization of the psychiatric yardstick as an administrative tool was not characterized by steady and positive development. Within separate correctional units, clinical workers often differed sharply in philosophy and practice, thus inviting criticism from many fronts. Fortunately, alert administrators began to adopt the

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clinical approach and greatly assisted clinicians in resolving many of their problems.

For example, for some time New York State penologists felt that the diagnosis of "psychopathic personality" was applied too loosely. Recognizing this difficulty, in 1940 the Commissioner of Correction, John A. Lyons, designated a committee on classification to reexamine the subject. On the basis of the committee findings, it was recommended that greater care be exercised in the definition of psychopathy, and at that time the classification presented below was officially adopted by the New York State Department of Correction:

PSYCHIATRIC CLASSIFICATION

- I. *Normal*
 - (a) Without significant deviation
 - (b) With moderate personality deviation
 - (c) With pronounced personality deviation
 - (d) With intellectual inferiorities
 - 1. Borderline
 - 2. Asymmetric intellectual development
- II. *Feeble-minded*
- III. *Neuropathic*
 - (a) Psychopathic
 - 1. Schizoid
 - 2. Paranoid
 - 3. Egocentric
 - 4. Hysterical
 - 5. Sexual
 - 6. Others
 - (b) Psychoneurotic
 - (c) Alcoholic
 - (d) Drug Addict
 - (e) Epileptic
 - (f) Post-encephalitic
 - (g) Other brain-nerve abnormalities with psychosis
- IV. *Psychotic*
- V. *Potentially Psychotic*

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Perhaps a helpful way of appreciating what confronts the psychiatrist upon the application of this system is to examine the conclusions from a report on the psychiatric findings on 2,000 consecutive cases of admission to a New York State Prison.

Evaluating Inmate Personalities: The diagnostic or classification phase of clinical work remains a general prerequisite to any effective program of adjustment and treatment. Skeptics object to any great emphasis on this phase of the work and consider it obsolete, protesting that it is simply a descriptive or labelling process. They often critically point out that a great number of men are routinely classified as "psychopathic personalities", a term many people use as a synonym for "recidivism". But, by its very vagueness, this term has lost meaning in well-informed psychiatric circles, and today carries only limited diagnostic implications. In some instances it is even limited in prognostic value. However valid these criticisms may be, it remains essential that we continue to take inventory and to organize clinical findings, if we are to give them dynamic significance. It is only through the careful sorting and interpretation of scientific data that such studies will be productive of useful hypotheses. For both practical and theoretical purposes, improvement in classification technique is advisable and possible, and will ultimately contribute to a better understanding of etiology and treatment.

The Normal, Feeble-minded, and Psychotic Groups are too well known to warrant much discussion. The Psychopathic Group, however, numerically large, presents by far the most difficult and interesting problems.

Psychopathy: It is important to note from the start that the psychopath does not represent a unified group. To psychiatric workers with limited prison experience, the psychopath is generally conceived of as an hereditary and constitutional type, — so much so that the title very often given is that of "inferior constitutional psychopathy". Electroencephalographic studies, still inconclusive, are used by some to strengthen this viewpoint. To the prison worker, however, the large group

classified as psychopaths do not reveal hereditary and constitutional foundations. On the contrary, the mounting mass of evidence shows that they are personalities *which are psychologically made and not born*. To avoid confusion for the lay worker who attempts to visualize the psychopath in terms of a well-defined entity, it is more reasonable to present the psychopathic concept as one embracing *a whole series of pathological behavior groups*. Experience with prisoners leads to the observation that these groups are not only descriptively different, but that they are dissimilar in etiology and in course of development.

Psychopaths in general adapt themselves poorly to social pressures and responsibility. They react rigidly to new experiences and appear to be unable to synthesize such experiences into integrated and normal behavior. Emotional development is characteristically fixed at earlier and more infantile levels. As one surveys carefully the history of the development of the psychopath, the impression is gained that traumatizing experiences have scarred the personality very early in its development. Emotional deprivation is a common factor, as is also the incomplete or inadequate identification with parent and parent substitutes. The psychologically abnormal personality evolves slowly until it receives official recognition in the court or in the correctional institution.

The "episode" is common with psychopaths. Periods of apparent conformance are interrupted by intensified episodes of instability and misconduct. Psychopathy is truly a chronic and progressive maladaptive type of psychological reaction which eventually may develop into a fixed pattern. The failure to respond to punishment, or to the threat of punishment, is not surprising.

The anti-social experience is constantly a part of the abnormal mental process. When such behavior is examined, it is seen as a substitutive or compensatory expression of underlying tension and conflict. So constant is this observation that certain investigators regard the psychopath as neurotic, and the term "neurotic character" has been used. It is more a fruit-

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ful approach for those who seek to understand the psychopath to look upon his behavior not as meaningless expressions but as symptoms intimately connected with unhealthy childhood experiences and unresolved conflicts. The psychiatric classification used in the aforementioned study closely approximates those in common use. It is largely descriptive, and for this reason has its defects. On the other hand, it crudely classifies a pathological type of pattern to which the inmate belongs.

In the classification of 2,000 consecutive court admissions to the maximum security prison at Attica, the examiner tried to avoid "psychopathic personality" as a catch-all for every problem of chronic maladjustment. It was recognized that, in the past, the hesitation to call a maladjusted individual "normal" led in many instances to his inclusion in the psychopathic group. On the other hand, many were so labelled because of a reluctance to call them "psychopaths". This problem is still with us. For this reason, an intermediary classification of "normal with moderate or pronounced personality problems" is used.

The term "Egocentric" is applied to one of the more interesting and common groups of psychopaths. The members of this group are known for their hostile and aggressive behavior, with an exaggerated sense of importance and a compelling need to deprecate others, and their constant aggressive and unconceding attitude, which finds them continually at loggerheads with others. Critics may validly take issue with this term, maintaining that the egopathic reaction characterizes generally not only the psychopathic criminal but also the normal one. It is clear that this whole subject of egocentricity needs to be redefined. Egocentricities are of different types and differ in their clinical significance. An egocentric gunman with his compelling need to assert himself at the expense of others and to reassure himself of his strength and masculinity, works off his problems through aggression. He presents a different type of egocentricity than that of the relatively unaggressive, narcissistic swindler who tries to enact his vain-glorious role through verbalism and deception. The egocen-

tricity of this second type (probably classified by some as "semantic dementia" and by others as "hysterical") differs from the classical egocentricity which is observed in the schizoid personality, whose odd and queer behavior is the result of withdrawal of interests, more or less incomplete, from the world about him.

These egopathic reactions are clinically different, and further study is required to understand them. They may or may not be dependent upon the degree of emotional transference that the individual has for others. For instance, the egocentric robber seems to need people in order to mirror his need to appear tough and strong: the swindling, verbose psychopath, with few aggressive trends, but with a richer fantasy life, has less touch with reality; while the schizoid personality divests himself and his interests more completely from people and reality. From the egocentric robber through the verbose, ingratiating fraud, to the lone wolf thief, relationship to reality becomes progressively more disturbed, and the prognosis from the standpoint of individual adjustment appears to maintain the same order.

It is clear that psychiatric efforts must be directed toward understanding psychopaths in a dynamic manner rather than toward treating them as static unities, and whenever the diagnosis of "psychopathic personality" is made there should be included a brief summary describing the type, the significance, and the character of the pathological mechanisms at work.

Therapeutic Classification: Because of the increasing emphasis placed on the treatment aspect of the prisoner, a third classification has been used: a therapeutic classification. Here the individual is described and analyzed on the basis of his specific needs rather than on the basis of his specific personality makeup. It emphasizes treatment rather than diagnosis. It is intended primarily to keep in the foreground the idea that something must be done for the disabled personality of the individual inmate. Such a classification must be the stimula-

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tion toward more specific and scientific types of programs for individualized care.

It is precisely here that individualized recommendations conflict in many respects with practical institutional situations and, very often, with the impatient demands of the non-specialist who wants treatment by formula. Too many of the non-clinical personnel in correctional institutions fail to understand that the techniques of mental treatment cannot be reduced in all instances to simple and specific prescriptions. The psychiatrist cannot always subscribe to this request for simplification. He is ever mindful of the need to translate his theoretical findings and recommendations into a terminology which can be easily utilized by the non-technical worker, but it is also his responsibility to make certain that these concepts are not destroyed in this process of translation, nor his recommendations misapplied. Until clinical units are organized on a more adequate basis, too much cannot be expected from the utilization of a therapeutic classification system.

Assignment Activities and Treatment: Adequate understanding and classification is truly the beginning of a treatment program. The findings usually determine the course of assignments and programs. The psychiatric findings are given expression in roughly two ways: (1) indirectly utilized through the various agencies of the total prison community; (2) directly used where the need calls for them by the specific techniques of the psychiatric therapist.

It is the responsibility of the clinic to encourage full use of every facility in the institution among its personnel to stimulate readjustment and stability for prisoners. It constantly must impress upon those who supervise and manage that the mental treatment of the individual is not only a science but an art. The traditional rule of thumb philosophies must certainly be replaced, and are already noticeably being sloughed off except for the few die-hards. Meanwhile, clinical workers recognize that the treatment program must adapt itself to the administrative and institutional conditions found. Failure of the clinic to make this adjustment can jeopardize the entire

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program. With increased education and knowledge of the way the clinic functions, and with proof of certain achievements, moderate though they may be, the time will come when these conditions can be reversed, and institutions will advantageously adapt themselves about the clinical program for purposes of management and treatment.

One of the important psychiatric objectives in the process of treatment is to enable the individual to gain insight in order to get well. If the offender, by whatever means possible, is able to broaden his viewpoint, to see and to feel the many influences which contributed to his distorted social viewpoint, and is able to see and to feel the influences that have fed his anti-social drives, the path to normal adjustment becomes more reasonable and hopeful.

The achievement of insight for the prisoner, however, does not take place easily without increasing insight into the process on the part of correctional workers. Their cooperation and collaboration is an essential part of any successful program. The worker must understand the principles of mental health and treatment, and must lend himself to their application. Little is achieved in working with prisoners when those in charge resist. These resistances are usually the result either of ignorance or prejudice, but they are sufficient to impair the work of the therapeutic plan.

Mindful of the need to make every correctional worker at least in some part treatment-minded, the progressive institution of today fosters seminars, clinics, and intensive courses on the subject of treatment. It gradually imparts to members of the personnel the viewpoint that the man who is in prison is functionally bad. When administrative procedures eventually will center around treatment programs, rather than expect the treatment plan to mold itself around antiquated institutional procedures, an important step will have been taken in the right direction.

A striking benefit from the adoption of the psychiatric view point is perhaps best seen in the handling of disciplinary cases. Where courageous disciplinarians have shown a willing-

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ness to base the management of their disciplinary cases around clinical studies and observations, a general reduction takes place in the number of cases requiring severe disciplinary measures. In working with disciplinary problems (and for that matter with prisoners in general) the psychiatrist must always be mindful of the repressive effects of institutional confinement. He is often concerned with the dangers inherent in the ways in which men become conformists. Surface adjustments to repressive conditions frequently conceal incipient stages of personality disease or disorder. The clinical staff must be alert to take countermeasures whenever possible and to ease the many unpublicized repressive influences of the average institution.

Personalities of prisoners rarely remain stationary. Some progress in the direction of healthy and responsible patterns; others are inclined to deteriorate into inadequate and hopeless adjustments. Those who can profit by the total therapeutic treatment of the institutions are able to avoid many disastrous personality reactions which the usual stresses and pressures of prison life impose on the individual. The average prisoner reacts poorly to stress; his index of adaptation to general responsibility has always been low. In the more confining and restricted atmosphere of prison he can easily develop more unhealthy pathological reactions.

COMMON REACTIONS TO CONFINEMENT

1. *Somatization*

Energies and tensions channelled into physical disturbances.

2. *Anxiety States*

Tensive-Panic-Fear reactions.

3. *Reference States*

Paranoid episodes in connection with homosexual conflicts — guilt.

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4. *Excitements*—Sham Rage
(Surrender of cortical activity to sympathetic discharges.)
5. *Escape Reactions*
Malingering (Conscious and unconscious)
Ganser Syndrome (States of idiocy—confusion, etc.)
6. *Depressions* (reactive)
7. *Chronic Reactions*
Pseudo-adaptation via path of stupefaction.
Regression to lower levels of adaptation which eliminates need for *conflict state*.
8. *Loss of Interest*
Unable to concentrate, to read, to write.
Prefer to remain in segregation.
Deterioration to simple level of adjustment.

In a repressive atmosphere, tensions and conflicts of the prisoner can readily become somatized. His emotional tensions are channelled off into physical complaints. This is frequently indicated by the long line of prisoners at sick call. In the more closely segregated prisons, somatic complaints multiply, and in many instances acute somatic episodes develop. The anxiety and panic states are frequent, and vary in intensity. Conditions of self-reference develop, and the prisoner projects his fears and complaints upon others and develops ideas of reference. This frequently may be due to guilt in connection with a perverted sex practice, or it may be due to a betrayal of a failure to maintain regularity of allegiance to other inmates. These states of reference go into more acute paranoid episodes which often require hospitalization.

The prisoner frequently reacts to the confining experience with mental explosions. The attack of sham rage is common. At times the prisoner will attempt to get away from the unfavorable environment through malingering or through simulation of insanity, frequently at unconscious levels. The bizarre

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and exaggerated behavior is not conforming to the usual clinical psychosis. Depressions occur, but they are not as frequent as the other conditions.

The above are relatively acute phenomena; it is important to note the states of stupefaction and pseudo-adaptations that take its place. Groups of prisoners in a constant state of conflict gradually resort to more primitive levels of behavior. The mental horizons are restricted; the individual can follow life only on a very simple plane, and he usually seeks the seclusion of the segregated cell. Mental effort becomes difficult, he is no longer able even to maintain his interests in reading and writing, and gradually he sinks into a state of mental inertia. This gradual, regressive phenomenon takes place most frequently in the segregated cases. It is important to note that these men become conformists only through a process of deterioration. With all the progressive measures which are taken in a modern prison, the incident of psychoses requiring confinement to mental institutions remains between 1 and 2%. Where repressive influences are more intense, the number of breakdowns increases. In a general way it can be said that the number of breakdowns, both disciplinary and mental, can serve as an index of the restrictive character of the institution.

In the assignment of inmates—one of the functions of the classification clinic — many theoretical considerations must yield to practical demands of the institutional setup. As time goes on, industrial and maintenance programs will be more largely determined by what they have to contribute to inmates rather than what prisoners can contribute to specific occupational activities. Many an industrial shop was set up on the theory that habits of work could be inculcated in the offender to his advantage and at the same time provide proper utilization of his labors for the institution's benefit. However, in practice it is shown that habits of work are difficult to infuse without satisfying the interest content of the personality concerned. A large part of this aspect of rehabilitation has been carried by the educational agencies within the prison.

Many well developed educational programs have been

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organized in modern prisons to fill basic deficiencies or needs. Because of the intimate relationships existing between clinics and educational units, arrangements have been developed to afford opportunities for therapeutic placement, where the educational program can be organized under clinical guidance. This parallels somewhat the practice of occupational therapy so advantageously used in our State Hospitals. In a few institutions, occupational therapists are found on educational staffs.

It is further helpful where classification clinics encourage each department in the prison to take an inventory of all opportunities which can be used profitably for treatment purposes. In these therapeutic placements the chief emphasis is to externalize the interests of the individual to more satisfying channels, whether practical or impractical.

Because of the deep-seated nature of the personality problems dealt with, a large part of the clinical work involves direct psychiatric treatment. Through direct contact the psychiatrist aims to understand the behavior of the individual and the meaning of his misconducts in relation to his general psychological and emotional conflicts. In turn, it must have the individual see his own behavior in the light of casual experience, so that he may emancipate himself from these emotional and compulsive drives, and so be able to seek more advantageous goals. Those who are experienced in prison practice recognize this as a very difficult phase of the work in view of the many resistances met in the course of the treatment. Unlike the psychiatric patient outside of prison, the resistance of the prisoner is much more intense. He usually does not treat his "offense" in terms of faulty personality functioning; he feels a need to place himself constantly in a better light. As his freedom is at stake, this element, together with the social rejections which he may have experienced, generate all types of rationalistic mechanisms which lend justification and even propriety to his criminal behavior. The general tendency for the prisoner is to base his crime on absolute need or to project it to social economic difficulties and to alcoholism. Moreover, as it is important favorably to impress authorities

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whose judgment will largely determine the length of imprisonment, defensive mechanisms are strongly stimulated. Can the offender freely reveal himself and face the danger of being more harshly charged? Some have already gone through the experience of being doubly penalized for honesty in revealing themselves. For these, retributive penalties have not been reduced by their candid admissions. Psychiatrists who are caught in this crossfire have recently advocated to parole commissioners the need to treat more liberally the man who is willing to bring up all the latent feelings and drives that he experiences. However, even the sixth sense of an offender will sense the danger if he permits latent aggressions and homicidal drives, sexual perversions, etc., to be brought to the surface, for there is a danger that more severe sanctions will be applied. Unconscious drives are frequently, by their very nature, dangerous and anti-social in content, and there is danger that certain parole officials may take these expressions at face value to the detriment of the offender and that they will fail to recognize that such material usually comes to the surface as a part of any psychiatric analysis. With prisoners, for the reasons just set forth, it is difficult to evaluate those memories which are amnesic and those which are consciously concealed. The use of drug analysis may contribute to the solution of this problem and more clearly reveal the significance of the criminal act.

The psychiatric interview, however, still remains the most dependable and best weapon that the psychiatrist has. As the psychiatric clinic becomes more readily a part of a prison program, and as suspicion of its functions are dissipated, offenders who are willing to avail themselves of the opportunity afforded by clinical contacts will profit. The personal relationships established, the feeling of being understood, wanted, and helped, the greater insight which follows, are all therapeutic achievements. It is necessary to emphasize the contribution that organized social work can offer to a clinical setup. By its very organization, it could more readily solve and handle

the many little problems that usually take the time and effort of the administrative officials.

The research phase of psychiatry in prison work has been greatly neglected. Constant critical appraisals and evaluations are essential. The multitude of platitudes in connection with the personality disorders of prisoners must be replaced by the more specific and proven psychological principles. This can be achieved by the thorough study of causes, behavior, and responses to treatment in a thoroughly controlled situation. The work of classification, then, rather than under-emphasized, should be intensified and must become a part of the carefully controlled research program. There is no other field in the study of psychiatry which is comparable to that of the correctional institutions. Here, in the controlled environment, is a true laboratory of human experience. Here, too, is where psychosis in the making can be observed. The research that will emerge from institutional studies will undoubtedly explode many of the explanations which are today used to account for the development of mental disease.

CHARACTER ASSAY IN DELINQUENCY

P. LIONEL GOITEIN, M.D.

Character may be defined as the sum total of enduring trait constellations within the individual of social and ethical significance, depending on habit formations. It is of the utmost importance that we have a definite measure of the characterological trends of every personality we are called on to adjudge, and ultimately rehabilitate, if he is to profit by the disciplinary experience. Herein lies the key to all successful modes of handling, in a custodial and therapeutic sense. So specific is the *character-pattern* of an individual that no blanket approach in institution routine can be tolerated nor be expected to work for all cases. The needs of diagnosis and treatment, prognosis and classification, economy and administrative detail, thus converge in a single demand for *unity of standard* and *method* in the field of inquiry. The advances of recent depth-studies in personality now makes this feasible in a qualitative way, such that a diagnostic label will be found to have a wealth of meaning behind it in all prognostication of crime.

Delinquency groups: For purposes of envisaging the main problem-groups of delinquency, we have indicated in the literature how it is possible to divide up crime according to its function of carrying through certain instinctual urges and satisfying certain biological needs. The main rubrics of character are found to be linked with such groups as are met with in a general population. This tentative classification still permits of the old legalistic descriptive terms, but sheds new light thereon by facilitating a grasp of the essential character of every type of antisocial violence, and by indicating the underlying urge behind each such form rather than by placing emphasis on the behavioral form itself. These biologic groups with an urge to crime, *e.g.*, with an inordinate love of weapons (*philiat*), fill our prisons, unlike the complementary groups

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which fill our asylums, consisting of those having an urge to *avoid* the like situations (*phobias*) and an inordinate *fear* of the self-same objects. The groups specifically compose: acrophilia, kleptophilia, pyrophilia, skopophilia, and homophilia. Such names are self-explanatory. Certain well defined character groups are aligned to the above trends.

History of growth: The process of character unfolding is a painful one. It is a gradual individual struggle toward perfection in conduct wherein constant adjustments have to be made on the part of the organism. No one arrives full-fledged at his native maturity, whether it be his emotional, intellectual, or material growth, without evidence of this struggle. This is especially true in the field of habit formation, from which character derives. Most of the danger points in development hold out the possibility of a neurotic break-down, a psychotic change, or a frank delinquency later. It proceeds in five stages (q. v.).

The roots of character: Two factors play the most significant part in the formation of character: the influences from the self's own development, and those provided by the forces of education from the outside world. These processes have largely fulfilled their purposes by the *third year* of life, by which time the main bodily habits are firmly established; for it is around the perfections (or imperfections) of habit control that the habitual ways of character are formed. If the basic nursery training be too strict, rigid, and uninspired, or the mother too demanding, then an over-moralistic attitude arises to life itself; indeed the firmness of the *sphincters* is an effort to conform to these impossible demands, to be reflected in later day *firmness* and hardness of character itself. The child decides just how far to go in exploring the pleasure of its varied excretions, *e.g.* in moulding them, holding them back, producing them to order, etc., so that the general trends of a pattern (to be seen in its later-day behaviors) relate to these bodily vicissitudes and primary drives. What applies (say) to the anal sphere in willingness and stubbornness, obstinance

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and freedom, complacency and incontinence, etc., of character, extends to many of the main orifices in the fixed stages from oral weaning to genital primacy that accompany, in the individual, a succession of mile-stones in his development for good or ill; the subject usually choosing as if voluntarily his particular *zone* of emphasis, his fascination point of "fixation."

Fixation: The main fixation point where instinct becomes blocked are at the levels of *orificial dominance* respectively of mouth, anus, urethra, gonads, and somatic orifices, whose sub-groups of reaction to stress determine specific behaviors. For example, the mouth is the oral sphere, hence libido goes through a phase of oral *masochism* when the delight in passive reception (nourishment) is strongest; or oral *sadism* when the pleasure of biting or squeezing (*e.g.* the nipple) is uppermost; oral *narcissism* when the child's pride in the prowess of intake and retention is developed; and of oral *erotism*, when a beginning desire to express love by lip and tongue contiguity, etc., occurs. Each can be over-developed to the detriment of the next phase, so that at a later date there becomes manifest a full-blown symptomatology. This may prove to be of (say) oral sadistic genre, seen best in the child, or the adolescent, or only by the time he is grown up, depending on the repressive or compensatory factors at work. Why libido is halted at such points is not yet fully established; but if it be not concretized in character, it is thought it can still be rectified in later years. Naturally, the further back we go the more impervious is the behaviorism to successful therapy; that is why certain stammer forms (oral erotism), greeds and tyrannies, nail-biting and other behavior problems are so difficult to eradicate. What applies to one orifice has been worked out for all the others. We can speak of anal sadism, urethral erotism, etc., but here the literature must be consulted.

Main heads of character: Now character divides up succinctly under five heads; the libido classification suggests the assertive, constrained, fluent, reactive, and evolutionary type of character respectively. These subdivide endlessly according

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to *quality, degree, and zone* of function. If we are dealing (say) with oral assertion traits, there are sub-heads (of oral submission, oral optimism, and oral pessimism, also oral elation and oral dejection, oral dictation and oral martyrdom, etc.). It is these which play a part in motivation for delinquency, if the valencies supplying their libido remain unsatisfied. Similarly for constraint in character and the other traits. Certain well-recognized traits follow involvement in all these areas, as we shall show.

Environment: In later years the forces of discipline or encouragement, desire-to-please and gratify or frustrate, etc., also to dictate or ignore (in so far as these emanate from the parents or surrogates), make possible a worthy unfolding of character and its directives. According to the way a growing child conforms or rebels against its restraint and exercises selection in the models it will follow, its character norms are established. The fundamental environment of the early years is psychological in the placid or stormy temperament of the parent or nurse, whose dependability, excitability in crisis, staunchness, or crass stupidity will have determined a definite *pattern* for the infant, acceptable truly to their requirements; but, all too frequently, the apparent acquiescence only conceals a deeper spirit of revolt, too subtle for the average parent to notice, but subsequently breaking out in unmistakable form as *problem behavior*, ranging all the way from waywardness and revolt, underhandedness, filching and such like petty delinquency, up to the psychopathic or pathognomic behavior we know as crime. Symbolically, each is understandable; the robber endeavors to steal or filch the love denied him in youth, the fire-fiend has a burning passion for the mother of unrequited love (albeit on urinary levels of expression), the rapist has his incest longings denied in infancy, and so on. All in all, it is the emotional environment which moulds the instincts, fostering or repressing their outlet, each in turn in consonance with inner desire, while interacting always with forces unfolding from within. It is therefore to the fascination-points in this direction (usually called "fixation levels") that we must

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look for the distinguishing features of character, be it fixed in purpose, well-accentuated in certain directions, or frankly aberrated.

Measuring rods: The measure of preponderant character trends follows on the same lines for the delinquent as for the normal, except that this is found over-developed; in some instances, among psychopaths, who suffer indeed from a *character-osis* or character anomaly, rather than from neurosis proper (which is, of course, not necessarily a defect in character), though the two may be combined. One mode of measuring the character peculiarity is to determine the zone of origin by deciding the specific habit-trends involved. Here we must look to the extent of *social* manifestation as the key to the problem. For example, symptoms of *anal autonomy* (such as parsimony) can be of innate, acquired, characterologic, neurotic or psychotic degree; and it is only the peculiarity in the behavior of the subject or his social rejection (judgment) which acts as guides to its seriousness. The fundamentals of all such conduct are obstinate to persuasion and *cannot* be shifted in the absence of therapy (rather than punishment), but stabilizing elements in the familial or clinical setting may do much to obviate them. Another scale of seriousness within this framework of malignancy is the aberrancy mode of the individual himself; *i.e.*, whether his masochistic, sadistic, or narcissistic phase is being satisfied, or only his eroticistic or realistic stage. The nature of his aberrant behavioral trends will indicate in which phase they have origin. To the extent, then, that such miscreants disturb and bother their environment, or find their perverse character troublesome *to themselves*, can they be considered pathologic. Do they offend, draw attention, cause friction, or outrage common amenities of life? To this extent they are antisocial, involve others in their orbit of criminosis, and themselves in a conflict with the law sooner or later. The prophylaxis of such behavior in the growing years is thus obvious. The use of the various projective techniques (*e.g.*, of Murray, Rorschach, etc.) throw considerable light on character

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and can be used to measure the import of its failure of adaptation.

Aberrations: Now certain aberrancies of conduct stand out, attributable to character fixation or deviation. Following the five heads of enquiry, we may say that: (1) Oral aberrations are to be seen, *e.g.*, in gluttony, stammering, incurable optimism, fussiness, garrulity, extravagancy, and incorporation desire (corpulency), along with grandiose, nebulous and expansive ideation in consonance with the trait. The criminotic manifestation of all this is in crimes of assertive violence, and might be named *aciophilia* (craze for sharp instruments of power). (2) Anal aberrations, seen, *e.g.*, in hoarding, parsimony, cleanliness, self-denial, collecting fads, inflexibility, meticulousness, tyranny and conscientious (if obstinate) conservatism of habit. The criminotic manifestation of all this is in acquisitive crime (stealing, concealing, larcenies, etc.), which we may call *kleptophilia*. (3) Urethral aberration, seen in arson, love of water-falls, excessive fire insurance, over-ambition, etc., in other words, the burning ardor and the love of flux that finds criminal expression in *pyrophilia*, joy of fire-raising and flooding: the accompanying ipsatory phantasy is the clue. (4) Gonadal aberrations, seen in immoderation, immodesty, and incontinency in the erotic field (Peeping Toms), also love of exhibitionism and skatologic interests such as find criminotic form in rape, exhibiting, soliciting, etc.; we might call it *skopophilia* (love of the object). (5) Somatic aberrations, seen in hypochondriasis, inversion love, curiosity, over-experimentation, reactionary behavior and similar characteristic psychosomatic trends, whose criminotic form is in perverse practices (of Biblical reference); summed up in a biologic term, *homophilia*. On such lines we may come to grasp the undercurrents of crime and of legal technical terminology.

Preventive technics: To guard against instinctual outbursts of non-constructive asocial conduct of this order, the child's characterologic unfolding should be allowed to proceed smoothly, utilizing a process of nursing prophylaxis, designed

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to release rather than inhibit its best potentialities. There should be a few strong drives directed against its unfolding purposes, also crises to aggravate the difficult transition-stages in the child himself whereby unnecessary emphasis on fixation-points become structuralized in conduct. Rather it is necessary to speed on (each in its proper time) these stages as they mould character, so that he reaches the post-genital organization of libido, having successfully weathered the early storms, much as he would an attack of measles. Many delinquents are immature in other ways, in their social, affective, intellectual, and constitutional lives. A study on characterological lines seems necessary.

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PSYCHOMETRIC PROCEDURE IN PENAL AND CORRECTIONAL INSTITUTIONS

MILTON S. GURVITZ

Psychometric tests in a penal institution should and can be a vital aid to classification, contributing to the placing of an inmate in a role in the institution which will assure in the highest possible degree his eventual rehabilitation and adjustment to the institution. If careful and accurate attention is not paid to levels of intelligence, basic and acquired skills, and personality factors, not only will the inmate merely be "doing time", but he will prove to be a trouble-breeder and a thorn in the flesh of the administration.

I. TESTING FOR ABILITY

A. *Intelligence Testing*

Although of maximal importance, the testing of adults has long been a sadly neglected task. The history of intelligence testing of adult prisoners shows instances of large percentages of feeble-minded. It appears now that this was due to the tests used rather than to the populations tested. All careful researches in the past few years tend to prove that adult prisoners are equal in intelligence to the general population.

The testing of adults for mental ability must take as its prime consideration the fact that the performance on adult tests declines in a more or less progressive degree with age. Therefore, only test norms that compensate in this way should be considered for use in institutions for adults (that is, men and women 20 and over). At the time of writing only two tests meet this qualification: the Wechsler-Bellevue Adult Scale and the Lewisburg Revised Beta.

The Wechsler-Bellevue is an individual test designed especially for adult work. It is divided into two parts, Verbal

and Performance, and the total of these form the full scale. Thus, Verbal and Performance as well as Full Scale I. Q.'s are available. All of these I. Q.'s are compensated for age. Hence this test is the basic psychometric instrument for individual testing and should play a decisive role in all doubtful cases. The Gurvitz Short Form, standardized on Adult Prisoners, requiring only ten minutes to administer, and having an r of .90 with the Full Scale, is available.

A good group adult intelligence test should be, of course, a routine procedure, and the only one that we know of that compensates for age is the Lewisburg Revised Beta. This test was designed for adults, has 6 non-verbal sub-tests, and is so arranged as to handicap as little as possible those inmates with poor or no education. The test was restandardized on 1,065 inmates of a Federal Penitentiary chosen from a group of more than 1,900 because they conformed to the national criteria of education and socio-economic status as revealed in the 1940 Census for the same age groups. It has a correlation of .86 with the Wechsler-Bellevue and its I. Q.'s are in most cases equivalent to it. It is especially sensitive in detecting the feeble-minded; I. Q.'s are available from age 20 to 54.

The tests available for juvenile and youths are much more diverse. In the field of individual tests, two stand out above all others and should be adopted as standard. The Wechsler-Bellevue has already been described; its youth scale extends from the age of 10 to 19. The 1937 revision of the Stanford Binet is so well known as to make recommendation superfluous and it should be found in the armory of every psychologist who tests individuals below the age of 20.

There are innumerable group examinations available for this age group. A recommendation here would find many justifiable criticisms, and merits could be found in other tests. In our experience, however, the Kuhlman-Anderson 1941 revision, in the proper battery, represents the best possible compromise. The test is extremely well standardized, has a very high validity, and emphasizes "non-verbal, native ability, and power items."

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B. *Testing for Special Aptitudes.*

1. Mechanical and Vocational Aptitudes. Whenever inmates are to be selected for training in industry or vocations, their suitability should be ascertained by vocational aptitude tests; particularly is this true if an extensive program of vocational education is contemplated. For routine and semi-skilled jobs a minimum of testing is desirable, due to the large number of subjects who will be tested. The first criterion should be the paper formboard, which comprises subtest 4 in the Lewisburg Beta. This should be followed by the Revised Minnesota Paper Formboard, which is available in two forms and has carefully computed norms for adults, youths, and juveniles. Following this it is suggested that use be made of the Minnesota Rate of Manipulation Test, which measures placing and turning ability and is another well standardized instrument. These criteria should be enough to make accurate judgments for semi-skilled positions.

Where skilled workers are to be trained, a further program of testing will undoubtedly be necessary. The most important tests to be added to the previously described are the Minnesota Spatial Relations Test and the Stenquist Mechanical Aptitude Test. The Minnesota Spatial Relations introduces, as its name indicates, an entirely new factor which is extremely valuable in diagnosing the higher values of mechanical and engineering aptitude. The Stenquist has a somewhat different approach. It requires the assembly of common mechanical objects in graded difficulty and is eminently useful in detecting latent ability among relatively poorly educated inmates and those from rural areas. Where time permits, the MacQuarrie Test for Mechanical Ability is valuable and discriminatory. A limitation resides in its unfortunate propensity for penalizing the individual with a rural or even a rural non-farm background.

Institutions that maintain large staffs of inmate clerks will find a clerical aptitude test such as the Detroit Clerical Aptitudes Examination and the National Clerical Ability Tests

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to be distinctly advantageous for the placement of men in clerical positions.

2. Scholastic Achievement Tests. Where this function is not performed by the educational authorities, the psychologist should also administer tests of academic achievement. These should be restricted to the basic tools of reading, writing and arithmetic, and can furnish valuable data as to the ability of the inmate to handle the type of future employment upon which his eventual rehabilitation depends. In addition, these tests are profitably employed in grade placement in the institutional school system and for indications of the academic bases of skilled positions in the institution; in this respect useful as a supplement to I. Q. ratings.

Ideally, achievement tests should be designed to appeal to this age group and be standardized on adults. At the present time tests meeting such requirements are not available, and achievement tests standardized on and appealing to children are our only recourse. While there are better than 50 such tests on the market (and we have not had the opportunity to test them all), in our experience we have found the Stanford Achievement Test and the Metropolitan Achievement Test to be fairly satisfactory measuring instruments. The administrator should be extremely careful to see that the proper level of each test is applied to the extremes which an inmate population always produces. The tester must have available levels that will evaluate from near illiteracy to the highest professional and academic attainments. For men whose abilities cannot be suitably tested by the Stanford Achievement Test or the Metropolitan because they are designed to be used up to 9th or 8th grade respectively, a battery composed of the Barret-Ryan-Schrammel English Test and the Iowa Silent Reading Test — both in their higher forms — will be found to be adequate. Where evaluation of a few individuals is important, the Sones-Harry High School Achievement Test will be found satisfactory in assessing an individual's knowledge and skill.

3. Tests of Deterioration. The older the inmate we deal

with the more we come to include the factor of mental deterioration. Such a condition should be very carefully distinguished from the lower classifications of intelligence which it resembles in quantitative measurement. The condition may be due to several causes and is invariably associated with the psychoses and less frequently with the psychoneuroses. It also accompanies such diseases and conditions as C. N. S. lues, brain tumor, brain injury, arteriosclerosis, alcoholic debilitation, senility, etc.

The Rorschach test has been used extensively to disclose intracranial organic pathology. Piotrowski has utilized the sign approach and has discovered and indicated ten factors which point to such a condition. The use of the Rorschach for indicating organic pathology should be entrusted to the hands of the experienced and extremely skilled interpreter working in close cooperation with a neurologist.

Two less esoteric tests are also available. The Shipley-Hartford Retreat Scale is a self-administering test for use with adult literates who have had at least average intelligence before the deterioration process began. The test takes, at the maximum, twenty minutes to administer and is based on the principle that performance on an abstraction test will decline if deterioration takes place, while the vocabulary score will remain relatively stable.

A more recent and better standardized test for deterioration is the Hunt-Minnesota. In this, a much longer vocabulary scale is again the constant measure of the pre-decline ability of the subject, while an elaborate series of performance tests is the measure of the deterioration process. There is a full series of validating tests and the scores are compensated for age. The final result is expressed in terms of a T score. The test requires careful, precise administration and consumes more time than the Shipley. Results, however, are considered to be somewhat more reliable.

II. TESTING FOR CHARACTER AND PERSONALITY

Testing for character and personality serves three distinct

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purposes: (1) it aids in psychiatric diagnosis; (2) it assists in uncovering the motivations of crime; (3) it aids in distinguishing the finer shades of personality deviations from the normal.

It must be emphasized that for our needs the questionnaire and personality inventory are, for all practical purposes, useless. What is needed are instruments that will reveal character and personality in individuals who are anxious *not* to reveal this information. Our most successful techniques, therefore, incorporate methods by which the subject reveals himself in symbols which are not patently meaningful to him but which are revelatory to the examiner.

A. *The Rorschach Method*

The Rorschach method occupies a premier position in this field. The inmate is asked to tell what he sees on each of 10 cards containing ink blots, five of which are achromatic and five including bright color. The responses are tabulated by means of a complicated but efficient scoring system which reveals through the projection and recognition of movement, color, form, and shading not only the structural aspects of the personality and transitory effects upon it of the current situation, but also the intellectual potentiality and efficiency of the total organism. This method is in daily use in the diagnosis of the psychoses, the psychoneuroses, psychopathic personality, intracranial organic pathology, and feeble-mindedness. However, its most efficient use is in the detection and evaluation of imbalances, conflicts, and anxieties within the essentially normal personality (individuals not diagnosable).

The orthodox method of individual administration and scoring requires anywhere from one hour and a half to three hours or more in difficult cases, depending chiefly on the number of responses. The administrator requires specialized skill and training, and the method makes large demands on the energy and patience of the administrator and interpreter. To make this test available on a mass basis two modifications have been introduced: (1) the group method of administra-

tion and (2) the Harrower-Erickson multiple choice techniques based on group administration.

The group Rorschach has long been on an experimental basis and is now standardized to the point where it has become an accepted practice. The method of administration is modified by using projected slides of the blots so as faithfully to reproduce them on a screen in a darkened room, while the methods of administration and scoring are modified accordingly. It is now in practical use as a screening device in several penitentiaries and Army establishments. As has been stated, specially trained workers are required to administer and score both the individual and group Rorschach. So far as the multiple choice technique is concerned, Harrower-Erickson has so modified the test as to make it an entirely different procedure which uses the original projected slides but requires the testee to pick his responses from a number of choices already provided. It must be stated, however, that this latter procedure is still in the investigative phase, and it should, therefore, be used cautiously.

B. *The Thematic Apperception Test*

This test utilizes 20 pictures, suggestive of diverse situations regarding which the subject is instructed to compose a story by using each picture as a central theme. By employing such factors as imaginal productivity, organization, verbal conjunctivity, introspection, extropection, content, motivation, and attitudes, it is possible to analyze the stories produced and thus to obtain an insight into the inner life of the individual. It must be emphasized that the test is as yet nowhere near the standardization achieved by the Rorschach; but it nevertheless offers many possibilities for interpretation and experiment by psychologists with a dynamic approach to their field, while to the Freudian-oriented therapist it offers a goldmine of information. Its chief function is to provide personal and background information and motivation supplementary to the more formal stratification of the Rorschach.

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C. *Minnesota Multiphasic Personality Inventory*

This test is sufficiently different in approach, method, and results to warrant inclusion in any psychological arsenal. The subject is asked to answer questions contained on 500 cards by placing them in categories labeled respectively: *True*, *False*, and *Cannot Say*. The cards are then tabulated by a simple, ingenious method, and various personality factors are deduced by means of a key or combination of keys, the raw scores of which are translated into T (standard) scores. At present keys are available that are designed to measure: (1) veracity (L); (2) validity (F); (3) hypochondriasis (Hs); (4) depression (D); (5) hysteria (Hy); (6) psychopathic deviate (Pd); (7) masculinity—femininity (Mf); (8) paranoia (Pa); (9) psychasthenia (Pt); (10) schizophrenia (Sc); (11) hypomania (Ma). While the scale measuring psychopathic personality (Pd) is in many cases unreliable, the test as a whole has marked value, particularly where the specialized knowledge and training necessary for the Rorschach and the Thematic Apperception Test are not readily available.

III. ADMINISTRATION, RECORDING, AND EVALUATING OF TESTS

A. *Primary Testing*

The purpose of primary testing is to classify the incoming inmate roughly into broad intelligence, educational, and personality categories. This program involves the administration of a group intelligence test (the Lewisburg Beta for adults and the Kuhlman-Anderson for youths), an achievement test, and the group Rorschach to all inmates. Institutions which carry on a program of vocational training will also find the minimal program of mechanical aptitude testing to be a required item in primary testing.

With the proper number of assisting administrators, it will be found feasible to administer all the tests in one day even if the groups are large. The preferred order is first the Intelligence Test followed by the Achievement Tests, and then

the Group Rorschach in the afternoon. If mechanical aptitude tests are given they should not be included in the day's schedule. All tests should be administered as soon as possible after entering the institution and certainly not later than the second week after admission. Care should be taken to see that they are separated from such trauma as anti-disease or leucic "shots" or even unexpected detainers by at least 48 hours. If possible, there should be *no* custodial supervision in the examining room, which is most advantageously placed in the hospital. The room should be large enough to seat, without crowding, the largest group that is contemplated to enter during one week; larger groups should be divided and tested on separate days. There should be approximately two feet between each inmate in all directions and seats with desk arms are almost essential. Constant vigilance is the price that the examiner must pay for tests free from copying and coaching invalidity. While ventilation, temperature, and lighting are routine problems, they can never be ignored. The tests should be scored and rated as soon as possible after their administration.

B. *Retesting* ⁴

Retesting of inmates is designed to correct anomalies between the test results themselves, or between the tests and the inmate's background and history, and to confirm evidence of low intelligence and psychiatric deviation. Where the Intelligence Test indicates a high intelligence and the Rorschach a low one, or *vice versa*; where a college or a high school graduate has a low I. Q.; where there is great intrasubtest scatter on the Intelligence Test; and where the I. Q. is below 90, retesting for intelligence is indicated. Such retesting should be done as soon as possible after the group testing, and with the appropriate tests previously indicated.

The Group Rorschach's indications of pathological reactions should always be supplemented by the referrals from the psychiatric interview as a criterion for retesting by the full dress Rorschach, the Thematic Apperception, and the Minnesota Multiphasic Personality Inventory. The Rorschach is especially

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important at this time because it aids in the estimation of situational depressions and anxieties. This testing program should also be completed within a short time after the primary testing to allow the information so obtained to be used in the initial psychiatric and psychological report. Final evaluation of the submitted results should rest in the hands of the Psychiatrist or Clinical Psychologist.

C. *Special Testing*

Special testing includes all testing not done as a result of the initial program of testing and interview. In all cases where doubt remains after the quarantine period of retesting, the inmate is continued under the program of special testing. Special testing can be motivated in many ways. The most obvious has been mentioned, resolving the doubts remaining after the retesting period. Others cover the whole gamut of institutional activities and affairs. Occasionally an inmate will request retesting; if at all practicable the request should be granted. Men placed under observation or diagnosed as psychotic, psychoneurotic; psychopathic personality, or feeble-minded, will of course have their cases reviewed at periodic intervals and may, in many cases, call for special appropriate testing. Men coming up for parole should also be reviewed in this light and may receive special testing, particularly where induction into the armed forces is a factor. Specific requests for testing may also originate in other departments. The parole or social service division may wish to know what kind of job should be solicited for a man with a tentative release plan and no vocational training; the Classification Committee may wish to transfer a man to vocational training or in-service training for a skilled position in the institution and is undecided about his ability and requests information. It is here that the most intensive testing will be done and the most varied of tests used. In almost all cases the object is the complete picture of the man, and just because an estimate of vocational aptitude is desired this does not automatically rule out tests of intelligence

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and personality. Considering that vocational adjustment so often depends upon the latter factors, the obverse is also true.

D. *Classification and Rating*

The classification and rating of intelligence and vocational aptitude remain in the hands of the Psychometrician. Psychiatric classification and diagnosis is the province of the Psychiatrist and/or Clinical Psychologist, and the educational tests are usually turned over to the Education Department.

The evaluation of the intelligence test or tests should result in an eventual rating. The ratings must be thoroughly explained to the psychologically uninformed officials who deal with them as an administrative procedure. The following classification has been in use for years with excellent results:

TABLE I
INTELLIGENCE CLASSIFICATION*

<i>Classification</i>	<i>I. Q. Limits</i>
A Very Superior	I. Q. above 130
B Superior	I. Q. 120 to 129
C+ Above Average	I. Q. 110 to 119
C Average	I. Q. 90 to 109
C— Below Average	I. Q. 80 to 89
D Inferior	I. Q. 70 to 79
E Borderline, but not feeble-minded	A classification for individuals who test below I. Q. 70 but do not have the clinical picture of feeble-mindedness previous to confinement.
F. Defective, with diagnosis as to type and degree	This classification should be used for those who show the psychometric and clinical picture of feeble-mindedness; cases of deterioration should be carefully distinguished from feeble-mindedness and so diagnosed.

* Where the deterioration plays a part it should be added after the describing rubric. A threefold distinction of: with slight deterioration, moderate deterioration, and marked deterioration, will be found to be adequate.

Should retesting still leave some doubt, the classification should be prefaced by the word "tentative" and the individual

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is indicated for special testing in 60 days. This is continued until a permanent classification is determined.

The classification of vocational aptitude covers such a multitude of relative and conflicting details that it is inadvisable to rate it on an absolute or even relative scale, but it should be described in a clinical approach under the headings of: (1) Method of Attack, (2) Foresight and Planning Ability, (3) Perseveration and Persistence, (4) Response to Frustration, (5) Distractibility, (6) Grasp of the Task, (7) General Reaction, and (8) Recommendations and Conclusions.

E. *Records*

All records of test results are separated from the main Neuropsychiatric files where the actual tests are kept. These results can be conveniently kept on a single sheet for each man, using both sides if an extensive test program is in use. This Psychological Record Sheet should contain all test results, all psychological ratings, diagnoses, and pertinent information as to age, place of birth, education, sentence, type of crime, etc. Test information should not be skimmed. The final results are in most cases not in themselves sufficient; also to be included are such pertinent details as subtest scores, raw and weighted scores, T scores, etc. Wherever possible, these details should be supplemented by illustration in simple graphical form.

IV. MENTAL DEFICIENCY AND ITS DIAGNOSIS

The diagnosis of mental deficiency in penal and correctional institutions has long been a notorious one. Tulchin, in his *Intelligence and Crime*, has settled this question definitively. His data indicates that if there *is* any difference between the criminal group and a representative general population, it shows the criminal group to rate higher, although the difference is not significant. Therefore, the studies which show criminal groups to have a high percentage of feeble-minded ranging in most studies from 20% to 60% are due to the employment of a faulty test rather than to inferior human

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material. In our experience the actual percentage of feeble-minded will closely resemble the same percentage for a similiar cultural group outside the walls. This will usually approximate 3%.

The diagnosis of feeble-mindedness cannot be made upon the basis of psychometric tests alone; for adults, however, a Wechsler-Bellevue I. Q. of no higher than 70 and in most cases 65 is a prime requisite for the diagnosis, while in youths below 20 and in juveniles the 1937 Stanford Binet I. Q. should also fall below 70. Beside these quantitative standards, qualitative measures of social efficiency must also apply: (1) He should not be able to support himself except on an extremely limited subsistence level; (2) He should have demonstrated extremely poor judgment in his previous history; (3) Educational attainments must not exceed, at the maximum, 4th grade; (4) Vocational level can never be higher than the commonest kind of unskilled labor.

While the foregoing is sufficient to establish the level of intelligence, other conditions operate to determine whether the condition shall be termed feeble-mindedness: (1) The condition shall not have been the result of mental deterioration due to disease or injury after reaching maturity. (2) It should be permanent and beyond amelioration. (3) It should not be the result of blindness, deafness, or other sensory or motor defects. (4) It should be traceable to heredity, birth injury, trauma in early life, or severe cultural deprivation amounting to psychological atrophy.

Several tests will be found to be of special importance in the diagnosing of feeble-mindedness, especially where a history is absent, the subject is foreign born, or of races other than white are encountered. One of the most discriminating clinical tests in our experience at this level of intelligence is the Healy Pictorial Completion Test No. 1. Using 16 as an age divisor for adults, any subject showing an I. Q. below 70 evidences a very strong probability of feeble-mindedness. The Porteus Maze Test, in spite of the fact that it does not compensate for age, is extremely useful in testing non-English speaking inmates, espe-

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cially at this level and if under the age of 35. The Rorschach Examination is another very good indicator in the hands of a skilled interpreter and, in addition, this has the advantage of giving a qualitative analysis of the mental level.

V. THE PLACE OF PSYCHOLOGICAL PROCEDURES AND A RESEARCH PROGRAM IN A PENAL OR CORRECTIONAL INSTITUTION

Psychological procedures should have as their primary objective the provision for an independent, objective, and statistically valid means of obtaining information and of checking and verifying data obtained by means of the clinical evaluation or case history. It offers a check on and an addition to clinical and casework methods, and in some ways provides unique information. At present its greatest handicap is the fact that tests must be used that are in most cases ill adapted to penal work, particularly among adults. This is particularly true in the field of adult intelligence testing and in the evaluation of educational accomplishment.

What is badly needed is a program of research in our prisons and the collection of information that will begin to supply the tests and methods now so urgently wanted, as well as one which will continue to adapt the latest psychometric devices to prison work. Institutions of detention, housing, as they do, thousands of inmates, and processing many men each week, have at hand a huge human laboratory which, if properly utilized, can not only provide the tests and procedures necessary to investigate the multifarious aspects of the inmate intelligence, character, and behavior, but can lead the way to progress in general psychometrics, particularly in the adult field. Institutions such as these are practically the only ones that use, as a routine procedure, extensive testing programs on adults; and this unique opportunity should be grasped.

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ELECTROENCEPHALOGRAPHY: USE IN PENOLOGIC PRACTICE

DANIEL SILVERMAN, M. D.

I. THE ELECTROENCEPHALOGRAM

Introduction: Electroencephalography, a comparatively young science in this country, entails the recording and interpretation of the electrical activity of the brain. Because the brain potentials usually occur as rhythmic oscillations, the records or electroencephalograms (EEG) have been called "brain waves". The electroencephalograph is now recognized as a valuable tool in neuropsychiatry; it often gives pertinent diagnostic information in the epilepsies and organic brain diseases such as space-filling lesions, head traumata, vascular disorders, degenerations, infections and toxic states. It is a painless and relatively simple method for the localization of cerebral lesions. Furthermore, the EEG has become an important research technique, despite the fact that the underlying neuro-physiology is not clearly understood. In criminology, the EEG has a special place because of the discovery of electroencephalographic abnormalities in criminal psychopaths.

Instrumentation: A short article cannot do justice to the complex subject of instrumentation, technique and interpretation of electroencephalograms; the reader is referred to basic writings of Jasper²¹, Gibbs¹⁴, and others^{32, 22, 35, 40}. Because brain potentials are exceedingly minute, on the order of 5 to 100 millionths of a volt, a powerful and accurate vacuum-tube amplifier with a voltage-amplification factor of about ten million is needed to record without distortion frequencies between one-half and fifty per second. The reliability of the amplifier cannot be stressed too greatly; a poor instrument can lead to errors of interpretation and to utter confusion. Recordings are now made with an ink-writing or hot-point stylus on mov-

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ing paper tape; the generally accepted rate of the tape is thirty millimeters per second. Because the tracings from one area of the brain cannot be considered representative, a three-channel electroencephalograph, *i.e.* three independent amplifiers capable of recording the brain potentials from three areas of the cortex simultaneously, is needed for satisfactory clinical use.

Technique: Contact with the scalp is made through silver, silver chloride, or solder disc electrodes about 5 to 7 millimeters in diameter. The contact areas should first be cleansed with ether-alcohol swabs and the electrodes, after moistening the under surfaces with electrode paste, are securely fastened in place with collodion. The number of electrode placements varies with the purpose of the examination. For routine clinical work, a minimum of six scalp placements should be used to overlay the frontal, motor, and occipital areas of the brain on each side; usually, two temporal leads are added. Electrodes should be tested to assure low interelectrode resistance (below 10,000 ohms); high resistance or electrode artifacts in the electroencephalograms demand immediate replacement of the defective electrode. The patient is placed, well relaxed, in a reclining or sitting position in an electrically shielded and relatively quiet room. Equipment should be so arranged that the operator can view the patient during the procedure. While recording, the patient's eyes should be closed but he must be fully awake. A routine EEG should contain 15 to 20 minutes of tracing and include a two-minute hyperventilation sample. The usual procedure is to record the EEG from areas of one hemisphere simultaneously, then the other hemisphere, and finally from homologous areas of both hemispheres simultaneously. By using paired ear electrodes as a reference or "indifferent" electrode, and an "active" electrode over the cortex, the monopolar lead is obtained; this type of lead is most commonly employed for routine examination. The bipolar lead, *i.e.* from two electrodes over the cortex, gives much the same EEG picture and sometimes adds valuable information to the EEG. When bipolar leads are used in series, a focus of abnor-

mality may be shown by phrase reversal, *i.e.* waves that are positive in one channel and negative in another. The focus then lies under the lead common to the two channels (see Fig. 4 A). This special method is useful when monopolar leads do not definitely point to a suspected focus or when the electroencephalograph does not have four or more amplifiers. For suspected lesions in the vicinity of the third ventricle, the basal lead of Grinker¹⁷ may give diagnostic information; with this lead triangulation phase reversals must be employed (see Fig. 4 B). Whatever techniques are used, meticulous care should be exercised to produce stable electrical contacts and to reduce to a minimum the easily introduced mechanical artifacts; for the quality of the record is directly proportional to the ease and reliability of interpretation.

Interpretation: Though steps toward quantitative analysis of electroencephalograms are being made^{11, 49}, the interpretation of the EEG is still an art which must be learned through experience. Furthermore, the EEG has great variability among normals and no specificity (with one exception) in abnormal states. It is surprising then that encephalographers are in essential agreement about EEG criteria even though their terminology may vary.

The normal electroencephalogram (Fig. 1 A) is characterized by regular series or spindles of smooth 8 to 12 per second waves which may occupy from 5 to 95 percent of the record and which are most common in the parieto-occipital areas. These potentials have been called *Alpha* waves or the "Berger" rhythm. The normal record also contains low voltage (below 20 microvolts), fast activity from 18 to 32 per second, seen chiefly in the anterior head leads; these have been termed *Beta* waves. A certain amount of slow activity in the 6 to 8 per second range, less than 10 per cent of the total record, may be anticipated, but a normal record never contains paroxysmal bursts of high voltage activity. Attempts have been made to classify normal records further according to the percentage of Alpha waves^{8, 9} or according to the "dominant" frequency¹⁵;

these refinements have not yet proved to be of clinical value and their significance is still not understood. What has been shown is that the more care that is exercised in choosing a group of "normal" individuals, the closer the electroencephalogram approximates 100 per cent normals⁵⁰. In an "average" sample of adults, one may expect to find 10 to 15 per cent of records that do not meet the above standards of normalcy.

The abnormal electroencephalogram contains a significant percentage of rhythms slower than 8 per second (Fig. 1 C.) and/or fast activity of significant voltage over 13 per second. The slow waves have been called *Delta* waves by Walter⁴⁸. Generally speaking, the further the deviation in frequency from the 8 to 12 per second range, the higher the voltage, and the greater the percentage of time present, the more pathologic is the record. However, when abnormal rhythms appear paroxysmally, even though briefly, in an otherwise normal record, the total record may be considered definitely abnormal. Fast rhythms are often encountered as spikes, either single or multiple, or monophasic or diphasic. Many classifications of EEG abnormalities have been proposed; all rely upon the frequency, wave form, location and amplitude. Examples of typical abnormalities are given in Figures 2 and 3. These include paroxysmal 2 to 3 per second waves (Fig. 2 A.); 4 to 5 per second rhythms, sometimes "flat-topped", the so-called "psychomotor epilepsy" waves (Fig. 2 B.); 6 to 7 per second waves (Fig. 2 C.); diffuse slow rhythms (Fig. 2 D.); typical 3 per second flow wave and spike forms, the so-called "petit-mal epilepsy" waves (Fig. 2 E.); atypical slow waves and spiked rhythms (Fig. 3 A.); single spikes often with a slow wave component (4 to 6 per second) (Fig. 3 B.); multiple spikes and fast waves, the so-called "grand-mal epilepsy" record when it occurs paroxysmally (Fig. 3 C.); sharp waves usually 4 per second in frequency (Fig. 3 D.); and focal discharges (Fig. 3 E.). Frequencies under 2 per second are not commonly seen unless there is some disturbance of consciousness. Usually in any one record, abnormalities are multiple, *i.e.* there are combinations of the various frequencies and wave forms noted

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above. It was stated previously that there is no diagnostic specificity to the abnormal EEG, except for the 3 per second waves and spiked rhythm which is rarely found without a clinical history of epileptic seizures. The three forms of "epileptic" waves, petit-mal, psychomotor, and grand-mal, while seen more often in the respective types of epilepsy, are misleading and cannot be considered as diagnostic of a type of epilepsy. Paroxysmal rhythms in general are *suggestive* of epilepsy, but other rhythms are common to all organic brain diseases. Focal abnormalities in the EEG are of inestimable value to the clinician. When electrical foci are discovered in suspected brain tumor cases, these are usually sufficiently accurate for neurosurgical cases in about 90 per cent of the cases. Certain limitations must be borne in mind. The EEG (except for the basal lead) records only cortical activity; therefore sub-cortical extracerebral and cerebellar pathology, unless the cortex is also affected, does not show up in the EEG. Furthermore, abnormal activity is a product of living but malfunctioning brain tissue; thus extirpated, agenetic or completely atrophied tissue causes no electroencephalographic abnormality.

The borderline abnormal EEG is characterized by arrhythmia. Random slow waves and spikes might appear in these records, but they do not form a definite rhythm (Fig. 1 B.). Asynchronism or marked asymmetry between the hemispheres might be present; this may be of value in localization. Records in which abnormal rhythms (unless of the paroxysmal type) appear only on hyperventilation are also included in the borderline group.

The above discussion of electroencephalographic interpretation applies only to the adult EEG obtained under the basal conditions described. The EEG undergoes a fairly definite ontogenesis⁴⁶ and in children shows slower alpha activity with poor organization of rhythms. From the ages of 8 to 12 the EEG takes on its adult pattern. It is necessary to observe basal conditions because tension and disturbances in attention tend

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to "block" the alpha rhythm and because drowsiness introduces sleep rhythms which may be mistaken for abnormalities

II. THE ELECTROENCEPHALOGRAMS OF CRIMINALS

The electroencephalograms of male criminals were studied at the Medical Center for Federal Prisoners⁴⁴. Clinically 411 prisoners were classified under four large categories: psychopathic states (208 men), psychoses (80 men), normal mental status (60 men) and abnormalities of the central nervous system (63 men). The last group was included solely as a check on the competence of the technique employed in detecting abnormalities of the brain by the electroencephalogram. The distribution of the organic conditions were: neurosyphilis, 21 men; epilepsy, 31 men; post-traumatic encephalopathy, 6 men; miscellaneous diseases of the central nervous system, 5 men. Except in the psychopathic group and the group with organic abnormalities of the central nervous system, the men incarcerated for violation of the Selective Service law were excluded. The distribution of the group with psychoses was as follows: dementia praecox, 50 men (62.5 per cent); psychosis with psychopathic personalities, 10 men (12.5 per cent); psychosis with mental deficiency, 7 men (8.7 per cent); paranoia and paranoid conditions, 5 men (6.3 per cent); manic-depressive psychosis, 2 men (2.5 per cent); and psychosis, undiagnosed type, 6 men (7.5 per cent). Psychopaths were classified into three types according to the motivating forces⁴¹ of psychopathic behavior: hostile, 65 men (31.2 per cent); hedonistic, 60 men (28.9 per cent); and inadequate, 49 men (23.5 per cent). A fourth type was added, the homosexual, 34 men (16.3 per cent); these prisoners were considered relatively free from other psychopathic aberrations and were not ordinary criminals; most were sexual offenders from the Army⁴⁵. A normal control series consisted of 60 volunteers from the civilian and professional personnel of the institution and from a nearby Army post.

The electroencephalographic data in Table 1 are arranged in Figure 5 to illustrate the progressive frequency of electroencephalographic abnormalities from normal controls to

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patients with organic disease. It is apparent that the psychopathic prisoners approximated the prisoners with organic disease in the frequency (75 per cent) of borderline and abnormal electroencephalograms; the most abnormal were the hostile and hedonistic types of psychopaths. The significance of these startling findings will be discussed later.

The inclusion of psychopathic psychotic criminals in the psychotic groups was partly responsible for the high percentage of abnormalities (Table 1; 45 per cent). In the largest group of psychotic patients, those with schizophrenia, the electroencephalograms of 31 (62 per cent) were normal; those of 11 (22 per cent) were borderline, and those of 8 (16 per cent) were abnormal. This is comparable to the distribution of abnormalities found in civilian schizophrenic patients¹². Though several important differences between criminal and non-criminal psychotic patients were found in a previous study⁴², the electroencephalogram was of no help in explaining these differences.

Cursory neuropsychiatric examinations could not be expected to detect the less obvious psychopathic conditions among the "normal" criminals, and this fact may account for the larger percentage of electroencephalographic abnormalities in this group (26.7 per cent), as compared with that for the control, or personnel, groups (15 per cent). These data point toward the fact that the electroencephalogram is not significantly more pathologic for "normal" criminals and hence cannot be considered an aid in the diagnosis of the source of criminalism.

III. APPLICATIONS TO PROBLEMS IN CRIMINAL PSYCHOPATHS

Importance of the Psychopath: The criminal psychopath, though he may constitute only about 15 per cent of penal populations, far outweighs his numerical importance to the penologist, civil and military authorities, and the scientist. He is disruptive in the reformatory and prison, exercises a malevolent influence on other inmates, invites severe disciplinary measures from which he benefits little, and on his release commits more,

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and often more violent, crimes. He causes untold misery to his family, to people he has duped, and to social groups he has been in contact with. To the psychiatrist, he has long been a controversial subject, an enigma, unresponsive to any treatment.

Organic factors: To shed light on the nature of the disturbance, the etiologic factors, both psychogenic and organic, operative in seventy-five carefully selected typical psychopaths, were studied at the Medical Center for Federal Prisoners⁴¹. Meticulous neurologic examinations and electroencephalograms were performed on each patient. The case histories were rechecked for evidence of (a) a family history of epilepsy, (b) congenital defects, (c) birth trauma or anoxia, and (d) significant trauma to the brain, anoxia or infectious encephalopathy occurring before the age of 5 years.

On the basis of the case histories a cerebral pathologic process was thought possible in 15 patients and in an additional 5 it was believed probable. Six other patients suffered significant cerebral damage after the age of 5 and one probably did. The data are summarized in Table 2. Neurologic examination of the 75 patients revealed definite signs of non-specific disease of the central nervous system in three patients and suggestive signs in 18 patients. The neurologic findings, given in Table 3, were almost uniformly confined to the motor and extra-pyramidal systems. A history of prolonged enuresis, though it occurred frequently (33 per cent), was not included as a positive neurologic sign because of the psychogenic aspects of this symptom. The total number of patients with neurologic signs and/or histories suggestive of cerebral lesion was 39 (53 per cent). It must be emphasized that these patients were considered typical psychopaths and not persons with disturbances resulting from an organic lesion in the brain.

The most conclusive evidence for an organic (cerebral) basis for the psychopathic personality seems to be the electroencephalogram; 80 per cent of the 75 patients had abnormal or borderline encephalograms. The most prominent abnormality was a 6 per second rhythm originating diffusely from the

frontal and pre-frontal areas of the brain. These findings have been corroborated by the studies on psychopaths of Hill and Watterson¹⁹ and Knott and Gottlieb²⁸. Further confirmation is found in the discovery of electroencephalographic alterations by Jaspar and his co-workers²³ among behavior problem children or the potential psychopaths. They found in their group of 71 children (aged 2 to 16 years) that 73 per cent of the records were abnormal or borderline abnormal, and they described the most prominent abnormality as a 5 to 6 per second rhythm originating from the central and frontal regions of the head. Later investigators^{47, 30, 3, 4, 13} confirmed these observations. From these data it may be inferred that the psychopath possesses a brain which is malfunctioning and has been malfunctioning since early childhood.

Psychogenic factors: With the advent of the dynamic schools of psychiatry it was inevitable that new insights into the cause of psychopathic personality would be gained. The literature^{38, 1, 51, 33, 7} is too extensive to be reviewed in this article. The case material of this study presented abundant evidence for psychological traumata in childhood, and the personalities of 35 patients lent themselves to psychodynamic speculation. Severe emotional deprivation early in childhood, similar to the primary affect hunger of Levy²⁹, was prominent in 9 cases. Marked emotional insecurity during childhood was apparent in 10 cases. Here maladjusted, usually poverty-stricken parents, alcoholic fathers or inadequate mothers and broken homes did not afford the child the security necessary for maturation or the parental ego ideals necessary for development of the superego. Ten patients gave indications of severe unsolved Oedipus conflicts, and 6 patients of an oral fixation traceable to an extremely overindulgent parent (usually the mother), similar to the mechanism in chronic alcoholism described by Knight²⁷. For 25 other patients the early influences were detrimental (parental rejection, broken homes, etc.), but correlation with the development of personality was uncertain. Only 15 of the 75 psychopaths had presumably normal backgrounds and, for 6, verified information about childhood was

lacking. Factors such as these emphasize the inescapable importance of parent-child relationships in the development of the psychopathic personality syndrome.

Synthesis: From the data presented it may be concluded that nearly all the psychopaths in this study were born with or acquired in infancy a defective cerebrum, a physico-chemical abnormality which affects chiefly the frontal or "silent" areas of the brain. Certainly there are quantitative and qualitative variations in this defect. In some extreme types of psychopathic personality the result may be the organic hyperkinetic aggressiveness aptly described by Curran and Schilder as the forerunner of the "hostile" psychopathic state. In other extreme types the cerebral organization may be so defective that minor emotional crises suffice to set off the dynamics of the psychopathic personality; here the psychogenetic factors may not be apparent. In other psychopaths, the cerebral dysfunction may increase the sensitivity to the emotional traumas of childhood. Unstable reactions to these traumas, and inability to integrate new experiences into the growing personality, furthers the development of psychopathic modes of behavior. Psychopathic personality, then, may be viewed as a mental illness resulting from inborn or early acquired cerebral dysfunction and disturbed parent-child relationships.

Experiments in Therapy: Since treatment of psychopaths along psycho-therapeutic lines has not been fruitful, the knowledge that there is an important organic component in their illness opens up new vistas for therapy. Accordingly, the effects of various pharmacologic agents and petit-mal electroshock therapy were tried on volunteers from the psychopathic unit at the Medical Center for Federal Prisoners⁴³, using the EEG as a check. Petit-mal electroshock was given 2 to 3 times weekly; an EEG was taken before and after completion of treatment and weeks later if indicated¹⁶. Phenobarbital (2 grains), sodium dilantin (3 to 12 grains), benzedrine sulphate (15 to 20 milligrams), a combination of amytal (3 grains) and benzedrine sulphate (20 milligrams) and a placebo were

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put up in divided doses in gelatin capsules and given for 8 to 15 days before each breakfast and lunch. A careful clinical check was maintained at all times. The EEG was taken before treatment, from one to three hours after the last dose of medicine and several days later if indicated. The electroencephalograms were analyzed with particular reference to the pathologic features. A record was rated as "definitely" improved when better organization and fewer pathologic sequences were noted, with sufficient qualitative change to warrant reclassifying the EEG from abnormal to borderline or from borderline to normal.

Electroencephalographic results, given in Table 4, indicate that of the treatments given, sodium dilantin holds promise of alleviating the cerebral dysfunction of some psychopaths. An example of the electroencephalographic change is illustrated in Figure 6. The clinical effects of sodium dilantin were also favorable; subjectively, seven patients experienced a new sense of well being and repose, and the personnel reported five to be more cooperative, stable, reliable and less antagonistic. The clinical response to electroshock therapy was not impressive; a trend toward improvement on psychometric and Rorschach testing¹⁶ justifies continued experimentation with grand-mal rather than petit-mal shock therapy. However, there was a distinct tendency toward exaggeration of electroencephalographic abnormalities, which were slow to return to the pre-shock level (Figure 7). This suggests that the abnormally functioning brain of the psychopath is more sensitive to the physiologic effects of electroshock than the brain of the psychotic³⁷, and it served as a warning of the possibility of producing "spontaneous seizures"²⁵ with grand mal electroshocks.

Theoretical Implications: The electroencephalographic abnormalities and similar responses of epileptics and psychopaths to sodium dilantin suggests a relationship between the two disorders. Jasper, Soloman and Bradley²³ and others⁴⁷ have proposed that some behavior problem children were "epileptoid". Although "epileptic personality" is a much debated issue (cf. Erickson¹⁸) it is certainly seen frequently enough to be

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considered a phenomenon associated with the disease (cf. Noyes³⁴), and the description of this personality—egocentric, stubborn, antisocial—often bears a remarkable similarity to the psychopaths. Conversely, one sometimes sees symptoms in psychopaths which are very suspect of disorders of consciousness. For example, it was elicited from one typical psychopath that he had occasional “blank spells”, brief periods when he seemed to forget what he was doing or saying. He was never observed to have anything resembling petit-mal epilepsy and his complaint may have been an exaggeration of an ordinary phenomenon (distractibility). Yet this 20-year old youth had a markedly abnormal EEG—6 per second delta waves and a 3 per second rhythm on hyperventilation. A 22 year old psychopath exhibited periods of extreme rage and destructiveness, precipitated by frustration, after which he would become uncommunicative for several hours. Superficially, this behavior suggested an epileptic equivalent attack and his EEG was abnormal—a 6 per second rhythm and 3 per second waves on hyperventilation. If the foregoing has validity, then psychopathic behavior may be viewed in the same light as the convulsive state. Psychopathy should be, as epilepsy is, a symptom of various types of organic brain disease or an inborn constitutional abnormality (the “idiopathic”). That psychopathic behavior is associated with organic brain disease is fully attested to by psychiatric literature^{10, 2, 26, 3}; and, in fact, many postulate an “organic” etiology for the “idiopathic” psychopath^{23, 20, 6}. Whether one develops a convulsive or a personality disorder or *both* may depend upon anatomic and physiologic variations of this cerebral lesion or abnormality.

Another hypothesis concerning the nature of the disturbance has been proposed by Mangun³¹, who contends that the psychopath's brain, as well as his personality, is immature. In support of the latter idea, Hill and Watterson¹⁹ pointed out that the normal slow alpha activity of childhood is considered equivalent to pathologic delta activity when it is found in later adolescence or in adult life. This suggests the possibility that the psychopath's abnormal electroencephalogram

may eventually "mature" and become normal. To test the validity of this assumption, the electroencephalograms of psychopaths were arranged according to age groups (Table 5). It may be seen that there is a tendency to fewer abnormalities in the electroencephalogram as age increases. The final answer cannot be determined until subsequent clinical and electroencephalographic studies of the present psychopathic children and young adults are made in adult or in later adult life. The theory of "immaturity" is not incompatible with organic disease of the brain or with epilepsy. It is well known³⁹ that some epileptic patients, especially adolescents, tend to improve — that seizures become less frequent, and may even cease (cf. electroencephalographic studies of pyknolepsy³⁶). Gibbs¹⁵ found fewer electroencephalographic abnormalities in epileptic adults than in epileptic children. The promise that psychopaths may in later years improve and even "recover" is not generally accepted. No one knows what becomes of the youthful psychopaths. Some die of violence or in the electric chair; others receive long sentences and are taken "out of circulation"; some become the more astute swindlers, and some, the middle aged recidivists, pass as "normal" criminals. It is conceivable that a few recover sufficiently to lead a relatively normal and law-abiding existence.

Practical Implications: Therapeutic nihilism concerning psychopaths is no longer warranted. Not only is it possible for psychopaths to improve with maturity, but active therapy, in view of our enhanced knowledge in the essential psychopathology of the disorder, may be beneficial. Sodium dilantin may prove to be an opening wedge in the successful treatment of some psychopaths—should it be capable of suppressing the abnormal and often disastrous outbursts of psychopathic behavior, and should it prove effective in the establishment of rapport for thorough psychotherapeusis. The latter should never be overlooked, since the type of psychopathic personality — the particular symptomatology displayed — is determined largely by psychological trauma which undoubtedly contribute to the intensity of the personality disturbance.

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The demonstration of neuro-physiologic abnormalities and of the possibilities for therapy demand reorientation of medico-legal concepts and of methods of handling criminal psychopaths. Certainly existing methods are inadequate; psychopaths are discharged at expiration of their sentences with full knowledge that no "cure" or "rehabilitation" has been effected, and that they still represent a potential menace to society.

IV. CONCLUSIONS

The electroencephalograph, while of no aid in diagnosing the source of criminalism, is a potentially important tool in the study and management of the criminal psychopath. It promises to help solve the vexing problems of etiology, therapy and prognosis in psychopathy.

TABLE I.
ELECTROENCEPHALOGRAPHIC CLASSIFICATION
OF CRIMINALS AND CONTROLS*

<i>Classification</i>	<i>Normal</i>		<i>Borderline</i>		<i>Abnormal</i>	
	No.	%	No.	%	No.	%
Psychopaths	52	25.0	48	23.1	108	51.9
Hostile	13	20.0	16	24.6	36	55.4
Hedonistic	12	20.0	16	26.6	32	53.4
Inadequate	16	32.6	10	20.4	23	47.0
Homosexual	11	32.3	6	17.7	17	50.0
Psychotic Prisoners	44	55.0	17	21.2	29	23.8
Dementia						
Praecox	31	62.0	11	22.0	8	16.0
Other Psychoses	13	43.3	6	20.0	11	36.7
Normal Prisoners	44	72.3	9	15.0	7	11.7
Prisoners with						
'organic' disease						
of brain	11	17.5	10	15.8	42	66.7
Epilepsy	2	6.5	3	9.7	26	83.8
Other disease	9	28.2	7	21.8	16	50.0
Normal Controls	51	85.0	6	10.0	3	5.0

* Silverman, D. The electroencephalogram of criminals, *Arch. Neurol. Psychiat.*, 1944, 52, Table 4.

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TABLE II.

EVIDENCE OF CEREBRAL LESION IN HISTORIES OF TWENTY-SEVEN CRIMINAL PSYCHOPATHS*

Family history of Epilepsy	2
Congenital defects (minor)	3
Dystocia	9
Birth Trauma	5
Head injuries under 5 years of age	3
Head injuries over 5 years of age	7
Severe infection during infancy	3
Severe malnutrition during infancy	1

* Silverman, D. Clinical and electroencephalographic studies in criminal psychopaths, *Arch Neurol. Psychiat*, 1943, 50, Table 3.

TABLE III.

NEUROLOGIC SIGNS OBSERVED IN TWENTY-ONE CRIMINAL PSYCHOPATHS*

Inequality of deep tendon reflexes	7
Inequality of superficial abdominal reflexes	2
Questionable pathologic reflexes (Hoffman, Babinski, etc.)	7
Pathologic reflexes	3
Irregularity and reflex inequality of pupils	2
Internal Strabismus (congenital)	2
Unilateral weakness of face	4
Severe tremor	9
Incoordination (finger to nose test)	2
Impaired associated movements, unilateral	5
Dysarthria	5

Silverman, D. Clinical and electroencephalographic studies in criminal psychopaths, *Arch. Neurol. Psychiat*, Chicago, 1943, 50, Table 4

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TABLE IV.

EFFECT OF DRUGS AND PETIT-MAL ELECTROSHOCK ON THE ELECTROENCEPHALOGRAMS OF CRIMINAL PSYCHOPATHS*

	<i>E. E. G. Normal</i>	<i>Borderline E. E. G.</i>	<i>Abnormal E. E. G.</i>	<i>Significant E. E. G. Improvement</i>
Benzedrine Sulphate				
Before Therapy	2	6	7	
During Therapy	2	5	8	0
Sodium Dilantin				
Before Therapy	1	5	19	
During Therapy	2	11	12	8
Phenobarbital				
Before Therapy	1	6	8	
During Therapy	2	4	9	1
Amytal and Benzedrine				
Before Therapy	2	5	8	
During Therapy	2	5	8	0
Placebo				
Before Therapy	1	4	10	
During Therapy	1	4	10	0
Petit Mal Shock-Therapy				
Before Therapy	2	5	13	
After Therapy	2	5	13	0

* Silverman, D. The electroencephalograph and therapy of criminal psychopaths, *J. Crim. Psychopathol.*, 1944, 5, Table 1.

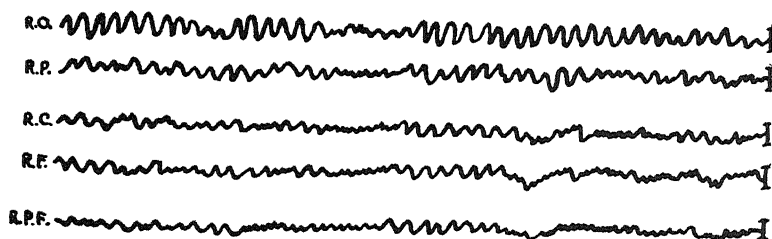
TABLE V.

RELATION OF AGE AND ELECTROENCEPHALOGRAM OF PSYCHOPATHIC CRIMINALS*

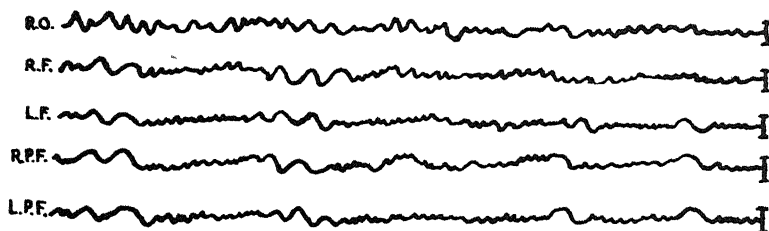
<i>Age Group</i>	<i>Normal</i>		<i>Electroencephalogram Borderline</i>		<i>Abnormal</i>	
	<i>No.</i>	<i>%</i>	<i>No.</i>	<i>%</i>	<i>No.</i>	<i>%</i>
16 - 19	8	18.7	10	23.2	25	58.2
20 - 24	23	25.9	21	23.6	45	50.5
25 - 29	13	27.1	10	20.8	25	52.1
30 and over	8	28.5	7	25.0	13	46.4

* Silverman, D. The electroencephalogram of Criminals, *Arch. Neurol. Psychiat.*, Chicago, 52, 1944, Table 5.

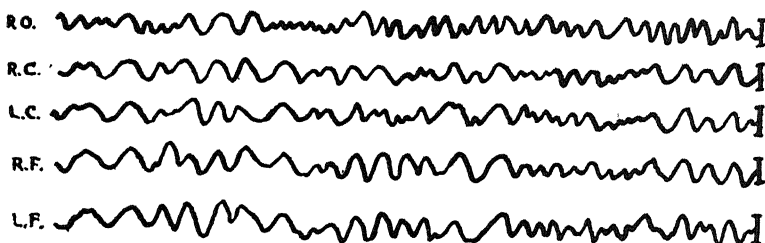
FIGURE I



A. NORMAL



B. BORDERLINE ABNORMAL



C. ABNORMAL

—
ONE SECOND

MONOPOLAR LEADS

CALIBRATIONS \sim 50 μ V.

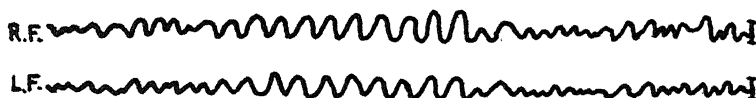
FIGURE II



A. 2-3 - C.P.S. RHYTHMS



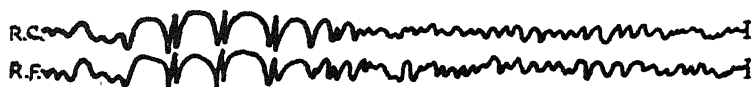
B. 4-5 - C.P.S. RHYTHMS



C. 6-7 - C.P.S. RHYTHMS



D. DIFFUSE SLOW RHYTHMS



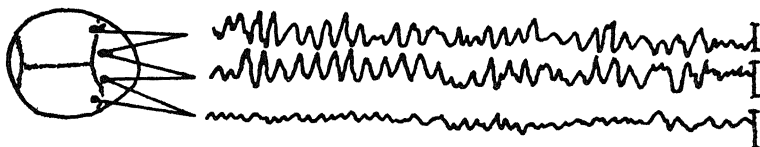
E. TYPICAL SLOW WAVE AND SPIKE RHYTHM

—|—|—|
ONE SECOND

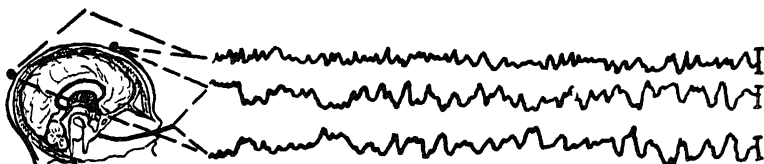
MONOPOLAR LEADS

CALIBRATIONS-50μV.

FIGURE IV



A. TRANS-FRONTAL PHASE REVERSAL



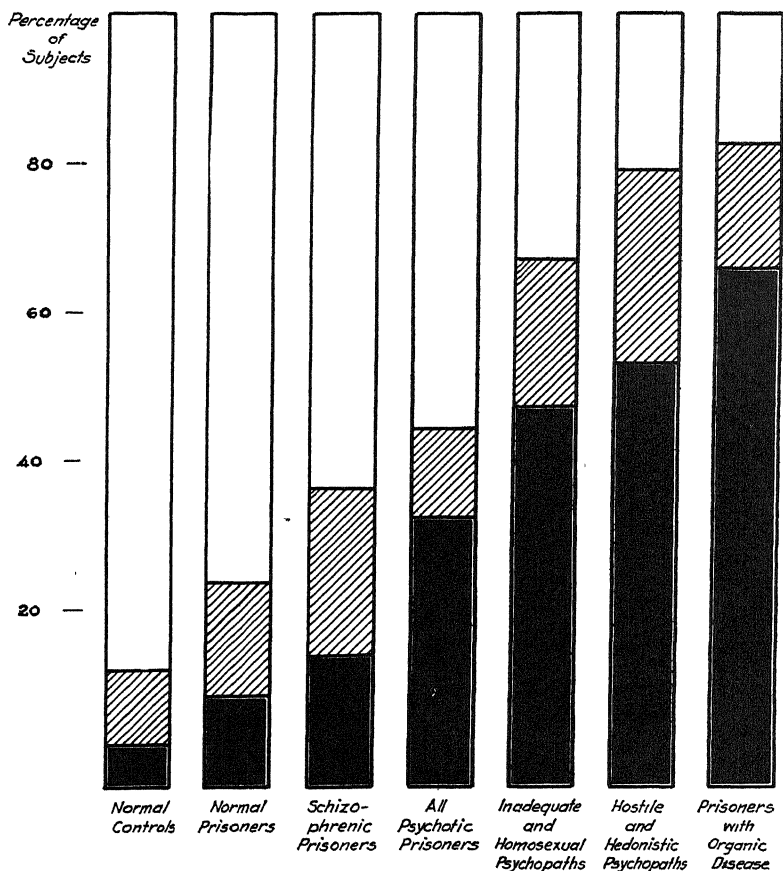
B. BASAL LEAD PHASE REVERSAL

—
ONE SECOND

CALIBRATIONS-50 μ v.

Fig. V

Relation of Frequency of Abnormal EEG
to
Criminal Groups and Normal Controls



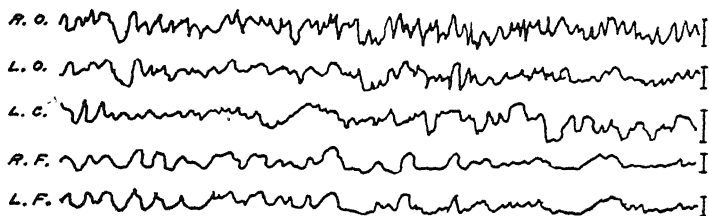
LEGEND: Normal EEG; Borderline Abnormal EEG; Abnormal EEG.

Rest

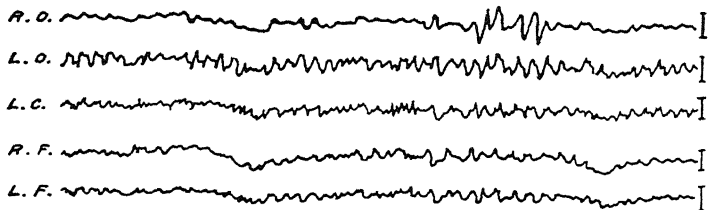
ELECTROENCEPHALOGRAPHY: USED IN PENOLOGIC PRACTICE

FIGURE-VI

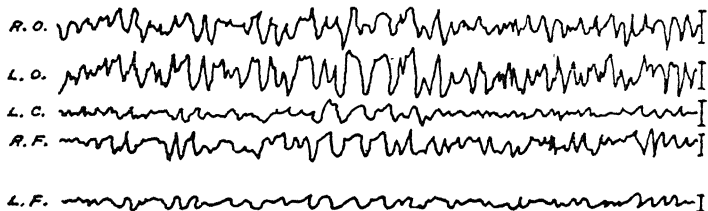
SODIUM DILANTIN



"A" BEFORE TREATMENT



"B" DURING TREATMENT



"C" AFTER TREATMENT

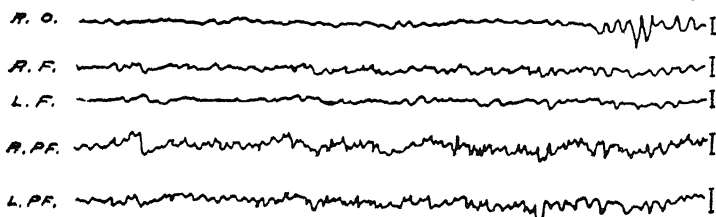
ONE SECOND

MONOPOLAR LEADS CALIBRATIONS - 50 μ V.

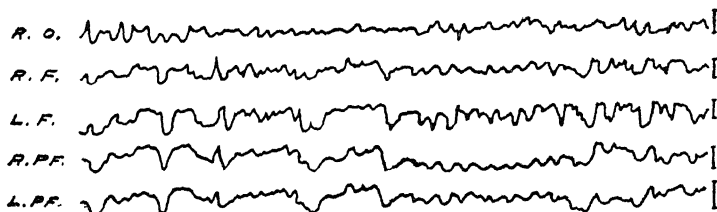
HANDBOOK OF CORRECTIONAL PSYCHOLOGY

FIGURE - VII

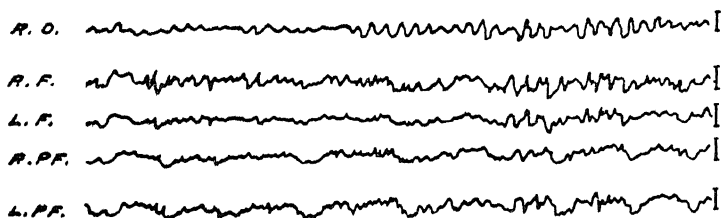
PETIT-MAL ELECTROSHOCK (20-TREATMENTS)



"A" BEFORE TREATMENT



"B" ONE WEEK AFTER COMPLETION OF THERAPY



"C" FOUR MONTHS AFTER COMPLETION OF THERAPY

ONE SECOND

MONOPOLAR LEADS

CALIBRATIONS - 50 MV.

ELECTROENCEPHALOGRAPHY: USED IN PENOLOGIC PRACTICE

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SUGAR METABOLISM IN ITS RELATION TO CRIMINOLOGY

JOSEPH WILDER, M D.

Fifteen years ago it would have seemed preposterous to assume that there could be any relation between sugar metabolism and crime. Since then our understanding of the importance of sugar metabolism for the normal functioning of the brain and mind has made great strides. Several factors are responsible for this rapid development, which is still far from having reached a climax. Those factors are: (1) The discovery of insulin (Banting and Best, 1921) and the observations of neuropsychiatric phenomena in animals and men following an overdosage of insulin; (2) the discovery of the clinical picture of "spontaneous hypoglycemia" (S. Harris¹⁹, 1924) *i.e.* of the fact that under pathological conditions the blood sugar may drop to subnormal levels just as after an overdosage of insulin, thus producing similar neuropsychiatric phenomena; (3) recent developments in endocrinology, internal medicine and brain pathology giving us better insight into the complexity of factors capable of producing this drop in blood sugar; (4) recent studies in brain physiology by Himwich and associates^{24, 25, 26} giving us an understanding of why, of all organs, just the nervous system responds so promptly to the fall and rise of the blood sugar; (5) the development of the method of electroencephalography (study of electrical brain waves) which gives us objective methods to follow up graphically the changes in brain functions coinciding with the changes in the level of blood sugar; (6) the observations made in the course of Sakel's insulin shock treatment of psychoses, in which overdosage of insulin is used purposely for the sake of therapy; (7) self-experiments of physicians with insulin.

INSULIN AND ITS EFFECTS ON THE MIND

Insulin causes a drop in blood sugar. In most animals

various reactions occur along with this hypoglycemia (sub-normal level of the sugar glucose or glucose in the blood). If the blood sugar drops below 45 mgm. per cent, we can witness convulsions and coma which leads to death if the sugar continues to drop. This reaction is so regular that it is being used for standardization of insulin. The symptoms of hypoglycemia can be stopped and reversed very promptly to normal by an injection of glucose or (slower) by feeding glucose or (still slower) by supplying starches or other carbohydrates from which glucose is formed in the body. As far as psychological studies of animals are possible, we can often observe psychological changes such as increased irritability, fright reactions, or even behavior interpreted as hallucinations.

In man similar observations were made only incidentally when by mistake too big a *dosis* of insulin was given or the effect of the regular *dosis* was intensified by failure to keep the proper diet, changes in the mode of life (exercise, etc.), concurrent diseases, menstruation, etc. With better knowledge of insulin and its effects, those incidental insulin reactions became less frequent but are still frequent enough to be a problem in the treatment of diabetes. The effect of insulin on the nervous system can be described in general lines, although quite a number of exceptions which we are not always able to explain can be found.

The normal fasting blood sugar in man is accepted by most authors as being 90-119 mgm. per cent, with a low margin of 80 and high margin of 120. If the sugar drops to levels of 60-70 mgm. per cent, and the level is maintained for some time, the patient exhibits symptoms of the autonomic and central nervous system. The most frequent autonomic symptoms are: hunger (or sometimes aversion against food), perspiration (often in the form of "cold" sweat), tremor of the hands, flushing or pallor of the face, cold extremities, rise or (more frequently) drop in the pulse rate and blood pressure level; among the less frequent symptoms we find salivation, lacrymation, palpitation, headache, dizziness, etc. The facial expression is often slightly changed by staring or frequent

blinking, etc. The corresponding mental changes are: slight dullness; weakness of concentration; the thinking process requires some effort; there is a difficulty in making decisions, even in things of minor importance; the mood might be depressed or a state of anxiety develops; there is a tendency to irritability or opposition.

If the sugar drops to levels of about 50-60 mgm. per cent, these changes are more marked. We can find transitory, more or less outspoken, neurological signs of focal character like double vision, vertigo, ataxia, disturbances of sensibility and speech disorders of aphasic or dysarthric character. The speech may be slow, stuttering or blurred; there might be *pallilalia* (rhythmic repetition of words or syllables) or *echolalia* (automatic repetition of words spoken to the patient); we also find *aphonia* (loss of voice) or *megaphonia* (speaking with excessively loud voice), etc. One must be careful, therefore, to differentiate between purely *motor* neurological disorders of speech without any psychological basis and the ordinary psychomotor changes of voice or speech denoting certain emotions. The same *pseudo-psychological* phenomenon, in reality devoid of any psychological meaning, can be seen in the muscles used for facial expression, gesticulation, walking, etc. We are dealing here, with release of certain motor automatisms usually inhibited by the action of the brain cortex. In addition to these misleading pseudo-psychological signs, the psychological functions, of course, suffer deeper alterations: the thinking power is definitely affected, the patient notices moments of arrest of thought; concentration becomes almost impossible; higher mental functions such as abstraction and thinking in categories are severely impaired; there are interesting disorders of orientation in space, time, and situation; the mental dullness increases to a dazed or unreal feeling, or to irresistible sleepiness; the lack of initiative increases to almost complete *abulia* (lack of willpower) and inability to make any decisions. It is very interesting—also in reference to the later discussion of criminality—that a restlessness and overactivity may be present along with this lack of initiative. A similar contrast exists

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between the prevalent mood of indifference and apathy, on one hand, and irritability, striking negativism, and tendency to opposition on the other.

If the blood sugar continues dropping to levels between 0 and 50 mgm. per cent, these phenomena are intensified on the somatic side to convulsions, chorea, motor and sensory paralyses, etc.; and on the psychic side to semi-stupor, sopor, stupor, and coma, or to atypical more or less severe psychotic pictures of various types: hysteria, delirium, amentia, manic, melancholic, schizophrenic syndromes, Korsakoff's psychosis, fugues, etc. Amnesia usually follows not only severe but sometimes even very slight hypoglycemic states.

An important feature of hypoglycemic reactions is that they are, as a rule, promptly reversible by an intravenous injection of glucose (10-50 cc. of a 20-50 per cent solution) or (less quickly) by hypodermoclysis, ingestion or tube feeding of glucose. The effect is often so miraculous that the needle is still in the patient's vein and a severe coma or psychosis has already been transformed into complete normalcy. Just this reversibility, unsurpassed by any other psychosomatic experiment, makes the study of hypoglycemia so valuable.

However, there is conclusive clinical and anatomical evidence to the effect that prolonged and repeated hypoglycemia may cause more or less severe permanent brain damage with its consequences for the patient's mentality.

SPONTANEOUS HYPOGLYCEMIA

Shortly after the discovery of insulin, S. Harris¹⁹ of Alabama (1924) published cases exhibiting symptoms absolutely identical with those observed after overdosage of insulin; this included the findings of hypoglycemia, parallelism between blood sugar and clinical symptoms, and prompt reversibility by glucose injection. His theory that these syndromes in man are due to an overproduction of insulin by the patient's own pancreas gland was soon confirmed by R. M. Wilder and associates⁶³ of the Mayo Clinic (1927), who actually found tumors (adenomas) of the islet cells of the pancreas and

showed that they contained great amounts of insulin. Since then a great number of severe cases of spontaneous hypoglycemia have been cured completely by surgical removal of such adenomas. Besides adenomas, simple hyperplasias and inflammations of the pancreas (often concomitant with gallbladder or stomach disease) are capable of causing spontaneous hypoglycemia.

The signs and symptoms of spontaneous hypoglycemia are identical with those of hypoglycemia induced by insulin. They have been described by this author^{54, 55, 56, 57, 58, 59, 60, 61, 62} and many others in a great number of publications. In dealing with such a case, the main difference is, of course, that no history of preceding insulin injection helps us in our diagnosis. Another difference is this: after insulin we observe, as a rule, "attacks" of hypoglycemia of comparatively brief duration which often, but not always, disappear spontaneously; in spontaneous hypoglycemia we very often have similar attacks. On the other hand, we also have cases of *chronic* hypoglycemia in which the blood sugar is permanently low and returns to the norm or near the norm only for short periods following meals or sugar injections. We therefore are likely to find here more *chronic* mental changes in addition to more or less frequent *spells* of deeper hypoglycemia. Apathy, indifference, dullness, laziness, lack of initiative and other personality changes are a *constant* feature, including, in some cases, chronic paranoic and other psychotic conditions as well. However, there is one test which allows us to differentiate these changes, often in previously normal persons, from purely psychogenic changes: in most cases a short or prolonged treatment with carbohydrates restores the previous personality, the psychotic trend disappears, the dullard becomes a leader, etc. All this, of course, parallels the increased level of blood sugar. The acute experiment is very impressive, *e.g.*, everybody may get negativistic or irritable under circumstances, but if this does not quite fit into the previous personality pattern and disappears suddenly after injection or ingestion of sugar, then it is grounds for suspecting hypoglycemia. Just the same, there are many

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persons who dawdle in the morning and cannot get ready in time. Some of them, however, change completely after breakfast, and the apartment and their own person are brought in order as if we shift from a slow-motion to a speeded-up camera. Such behavior calls for blood sugar studies.

We must keep in mind, however, that here and there a single dosage of insulin as well as chronic hypoglycemia may lead to irreparable anatomical brain damage which has been described many times in animal and man: hemorrhage, edema, degeneration of nerve cells, etc. The influence on the development of the brain in children, unfortunately, has never been studied.

FACTORS IN SPONTANEOUS HYPOGLYCEMIA

The sugar metabolism is directed and influenced by a great number of factors other than the islet cells of Langerhans in the pancreas. No wonder, then, that spontaneous hypoglycemia has been found as a consequence of a number of disorders other than pancreas disease. Severe cases, with fatal outcome, are frequent in destructions of anterior pituitary gland and adrenal cortex. Milder cases are not infrequent in brain diseases (especially in the hypothalamus) *e.g.*, trauma or encephalitis in hypothyroidism, muscle dystrophies, gastrointestinal and certain kidney diseases. Liver diseases are important since most poisons causing hypoglycemia act by way of the liver. Among these liver disorders are two American specialties: the "milk sickness" which decimated the population at the time when Lincoln was a child, and the sequelae of "smoke drinking".

Apart from diseases there are a number of conditions capable of producing hypoglycemia in susceptible persons: starvation, especially lack of carbohydrates; muscular overexertion; diarrhea and vomiting; lactation; and sometimes menstruation. There are interesting studies on the effect of spontaneous hypoglycemia on the efficiency of Marathon racers, or golf players. In sports as well as in the conduct of

war, the importance of sugar as emergency food is fully acknowledged.

How frequent is spontaneous hypoglycemia? It seems to be no less frequent than diabetes. Greenwood¹⁸, *e.g.*, found a fasting blood sugar below 70 mgm. per cent in 2.8 per cent of one thousand patients in a general ward and in 4.35 per cent out of two thousand cases in a psychopathic ward. Powell⁴¹ goes perhaps too far in assuming that one-sixth of our population has a tendency toward hypoglycemia. However, this does not mean that all those patients had clinical symptoms of hypoglycemia. Although it is true that many doctors and many patients fail to realize minor clinical symptoms, this is not the only cause of this discrepancy. We know that a number of factors play a role, like the depth and duration of the hypoglycemia and the individual susceptibility. Thus, *e.g.*, there are exceptional cases who do not show any symptoms with very low blood sugar and cases who get all the symptoms, reversible by injection of glucose, at levels well above the norm. For the problem of delinquency it is important to know that children, as a rule, not only show a more marked tendency to low blood sugar but seem to get symptoms quicker. Besides, certain symptoms are much more frequent in children, *e.g.*, vomiting, somnambulism, nightmares, epileptiform convulsions.

BRAIN AND HYPOGLYCEMIA

In recent years Himwich and associates^{24, 25} were able to furnish a satisfactory explanation of the fact that almost all clinical symptoms of hypoglycemia are neurological and psychiatric in character. By studying the sugar levels in the blood flowing toward the brain, and by other devices, they could prove conclusively that the brain holds a special place among the organs of the body; while almost all organs are able to mobilize their glycogen reserves in emergency and to produce their own sugar, the brain—although containing glycogen—is not capable of doing this, and is thus entirely dependent on the supply of sugar by the blood stream. If this drops, the intensity of the oxidation in the brain diminishes accordingly,

SUGAR METABOLISM IN ITS RELATION TO CRIMINOLOGY

since the glucose, by a series of complicated chemical processes in which Vitamin B₁ plays a role, is the main supplier of oxygen. Thus the glucose, although apparently not involved in the building and development of the brain, may be considered as its main fuel and its main source of energy. We assume that lack of glucose brings about a diminution in the intensity of the mental processes. If, nevertheless, the clinical symptoms of hypoglycemia impress us as *qualitative* as well as *quantitative* changes, we must keep in mind that not all parts and not all functions of the brain are equally vulnerable, and that, *e.g.*, phylo- and ontogenetically newer parts and higher, more recently acquired functions are the more vulnerable ones. Thus older and more primitive mechanisms are being freed from the inhibitory control of the cortex and, seemingly, new psychic qualities appear. However, other factors, like different chemical affinities to certain parts of the brain, may also play a role.

ELECTROENCEPHALOGRAPHY

For those who wish to study the general problems of brain physiology in hypoglycemia, or to follow up an individual case by objective and demonstrable methods, electroencephalography is a welcome help. That does not mean that the tracings of the electric potentials called brain waves present a picture specific for hypoglycemia. One cannot diagnose hypoglycemia from the pattern of brain waves. Nonetheless, we find a slowing of alpha frequency and an increase in the number of long waves as the state of consciousness changes (Hoagland and associates²⁷, Hill and Watterson²¹, Goodwin and associates¹⁷, Himwich and associates²⁶, and many others). We find similar changes in anoxia and other conditions of the brain. What interests us here is not a constantly abnormal record but rather temporary changes coinciding with a drop in blood sugar, and psychological symptoms. What makes it interesting and conclusive is the prompt restoration of this abnormal record to the norm by an injection of sugar or by other similar means.

Whether or not we shall be able in the future to coordi-

nate such temporary abnormal records with the constantly abnormal records found, *e.g.*, in irritable psychopaths, is still an open question. In this connection it might be of interest to quote a few data from the literature (Williams^{64, 65}; Brill and Seideman⁸; Hill and Watterson²¹): the percentage of abnormal records in highly selected flying personnel is 5 per cent; in R. A. M. C. personnel, 10 per cent; in mixed controls, 15 per cent; in mixed psychoneurotics, 26 per cent; in inadequate psychopaths, 32 per cent; in aggressive psychopaths, 65 per cent. Delinquency alone—without mental abnormalities—does not seem to be associated with abnormal electroencephalograms, but the number of cases studied is small. The problem of immaturity of the brain enters here, since Brill and Seidemann⁸ could show on children that the alpha frequency increases and incidence of slow activity diminishes with advancing age. Originally Jasper and associates²⁸, as well as Lindsley and Cutts³⁶, emphasized the frequency of abnormal electroencephalograms in bad-tempered irritable children and in "problem children". Since the patterns of brain waves in such cases are similar to those in hypoglycemia and anoxemia, and since our concept of the clinical symptoms in these conditions is that of a decrease in intensity of brain functions, the conclusion might be permissible that the psychological makeup of aggressive psychopaths may be also due to a lowering of brain functions. An example of the application of electroencephalography in a case of hypoglycemia in court procedure will be quoted later (Hill and Sargant²⁰).

INSULIN SHOCK TREATMENT AND HYPOGLYCEMIA

In Sakel's insulin shock treatment high doses of insulin are applied with the specific intention of lowering the blood sugar far below the normal level and producing unconsciousness (coma) with or without convulsions. This state is purposely maintained for a certain length of time, after which the blood sugar and the patient's condition are brought back to normal by injections and tube feeding of glucose. Many of the recent studies in brain physiology have been made on such

patients. The main objection against the conclusions of psychological character derived from those cases is, of course, that we are dealing here not with normal but psychotic individuals. On the other hand, certain phenomena are so regular in their appearance and disappearance, regardless of the kind of psychosis, and other—especially neurological—signs and symptoms are so foreign to the mental condition of the patient, that the cautious observer can make important discoveries about the cerebral and mental processes taking place here. There exists nowadays a vast literature on the subject of which we quote, for example, the papers by Frostig¹⁵, Angyal⁴, or Benedek⁶.

SELF-EXPERIMENTS WITH INSULIN

In questions of psychology we are particularly interested in self-observations of normal, reliable individuals. Although the number of self-experiments and self-observations with insulin is comparatively small, they are very important. The best self-observations have been reported by J. Wiedeking⁵³ and her collaborators. They confirm the mental symptomatology briefly described in the chapter on insulin and furnish striking illustrations. Thus, *e.g.*, one person reports about her feeling the lack of initiative and an inability to make decisions with the words: "I don't want to move or talk. To take a pencil from the table requires as much will power as climbing a mountain". Another person, in awaking from a moderate hypoglycemic state, says: "Now I begin to see clearer. I had a feeling as though I had passed into the beyond. What a strange situation. You are partly here partly far away. Everything was seen and heard as though it were behind a veil. I experienced an unbelievable indifference against everything". Another statement is: "I feel absolute indifference, register all I hear without adopting any special viewpoint. There are neither agreeable nor disagreeable memories". This loss of associations has also been noted on patients. We shall discuss later what features of these observations and self-observations could possibly have a relation to the psychology of crime.

HYPOGLYCEMIA AND CRIME

Criminal acts have been committed time and again in abnormal psychological conditions impairing judgment or self-control. Alcohol and other poisons, fever delirium, psychoses, epileptic equivalents, etc., are among the best known causes of mental conditions conducive to abnormal or criminal behavior. Since hypoglycemia is capable of producing more or less severe mental changes, followed mostly by amnesia, there is no reason why such acts should not occur in hypoglycemic states

Thus, E. P. Josslin³¹ in his classic book, *The Treatment of Diabetes Mellitus*, could foresee in 1937: "The importance of spontaneous hypoglycemia in a non-diabetic from a medico-legal standpoint is not to be lightly brushed aside. As yet I have seen no reference in the literature to its significance." However, a number of special difficulties arise in the evaluation of such cases. In insulin hypoglycemia (1) we often keep forgetting that a certain mental reaction is due to an insulin injection given 3 or 4 hours prior to the event; (2) the patient may be seen in a condition in which he is unable to inform us about the injection; (3) the patient may have complete amnesia in and after the hypoglycemic state and does not recall the injection. In case of spontaneous hypoglycemia the diagnosis is much more difficult. The disease (or syndrome) itself is not generally well known, and for the most part not recognized as such. Even the patient may not know he is sick. It offers such a variety of abnormal mental pictures that the diagnosis from the symptoms alone is very difficult. We ought at least to consider the possibility of spontaneous hypoglycemia whenever the crime is not sufficiently motivated; when the behavior of the criminal is peculiar, not quite in the line of his usual personality; whenever he suddenly awakens from his condition after ingestion of some food; there is amnesia; the man gives a history of any sort of "spells"; there are neurological signs or symptoms (convulsions, double vision, Babinski's sign, etc.). If we are dealing with a case

of chronic hypoglycemia, the proof of it is easy once the suspicion arises. It is more difficult in cases in which the hypoglycemia occurs in the form of single attacks, sometimes at great intervals, and most difficult in cases in which we are confronted by a single occasional hypoglycemia due to external factors like starvation. We shall discuss the diagnosis later. Here, of course, we are mainly interested in spontaneous hypoglycemia; criminal acts due to insulin injections serve rather as illustrations of possibilities, since they could just as well happen in spontaneous hypoglycemia.

J. Wilder⁵⁴ has compiled from the literature up to 1940 a list of crimes and infractions of law committed either under the influence of insulin or in a state of spontaneous hypoglycemia. The list includes: disorderly conduct, assault and battery, attempted suicide and homicide, cruelty against children or spouse, various sexual perversions and aggressions, false fire alarms, drunkenness, embezzlement, petty larceny, willful destruction of property, arson, slander, violation of traffic regulations.

Since then we found in the literature cases simply listed as habitual criminalism (Wheelon⁵²), of criminality in children (Anderson³), and of severe infractions of military discipline (Sercl⁴⁶), etc. In addition to these, some studies on sugar metabolism in criminals not suspected of hypoglycemia have been started (N. Rojas⁴³).

Generally, in outspoken psychotic states we find the typical acts against law and order, as we may find in catatonic, paranoid or epileptic states: first of all violent resistance against any form of restraint, then undressing in public, slanderous accusations against imaginary persecutors (Rud⁴⁵, Joltrain²⁹, J. Wilder⁵⁴), etc. Since those acts are committed in an obvious psychotic condition they do not constitute, as a rule, a major medico-legal problem. It is not important from a forensic point of view whether the catatonic state is due to hypoglycemia or to some other cause if only it is recognized as a catatonic state. The question of correct diagnosis is, of course, of paramount importance for the *treatment* of the

patient. But, on the other hand, the recognition of psychotic states as due to hypoglycemia may actually involve some special medico-legal difficulties. Since these states may occur and disappear sporadically, and the patient, unlike the catatonic patient, may be mentally normal in the interval, the diagnosis of the psychotic spell is not always easy to substantiate. We may add that the patient's own testimony may be highly misleading due to his amnesia. We feel certain that many cases of that sort remained unrecognized in the past. Even if the psychotic state of mind at the time of the crime as well as the suspicion of hypoglycemic etiology of this state were recognized, it still may be difficult to prove it. We shall discuss this difficulty in the section on diagnosis.

More interesting and more difficult are the cases in which the hypoglycemia did not produce a typical picture of psychosis. Although we encounter here a much greater variety of major and minor criminal acts, certain trends seem to be showing which will probably prove to be of greatest psychological and psychoanalytical interest. It is still questionable whether we know all that takes place in a hypoglycemic brain. Our own theory is that we are dealing with a simple quantitative decrease in the intensity of mental functions with the more recently acquired functions suffering first and most. If it is so, then an outspoken tendency to certain kinds of criminal behavior would help us to understand better both the working of the mind and the mechanism of criminality. Undoubtedly, we have hardly made a start in this direction, but the implications seem to be very great.

Among the special criminal tendencies, *i.e.*, criminal acts attempted and committed repeatedly in minor as well as major states of hypoglycemia, the following have attracted our attention because of their comparative frequency:

(1) *Theft, violence, petty larceny in connection with the frantic attempt to secure food*, especially sweets, a true, instinctive act of self-preservation. The patient—who often does not know that he is a patient—would run into a candy store and grab what first he can lay his hands on; he would order a

meal in a restaurant despite the fact that he has no money (Greenwood¹⁸), or he may forget to pay (Engelhard¹⁴). Since he frequently gives the impression of being drunk (Adlersberg¹, Duncan¹², Wanchope⁵¹, Bowen and Beck⁷), he is often detained or thrown out; in a characteristic way he resists violently manager, salesman, police. It is quite possible, as Duncan indicates, that the adrenalin-secretion provoked by the emotion of anger and counteracting the hypoglycemia also acts as a life-saving mechanism. In this case both the reckless acquisition of food and the aggressive emotion would be parts of the homeostasis, and would serve the purpose of maintaining a certain blood sugar level.

A most important psychological and socio-economic question arises here: that of relation of *hunger* to crime. We are only too prone to forget in our country and in our time what a powerful drive hunger is, the most powerful of all drives except thirst. Besides causing a powerful drive, the lack of food causes important psychological changes. Any number of proverbs in many languages express our age-old knowledge of this fact: "A hungry man is an angry man"; "those who eat cannot understand the hungry"; "the brain is the slave of the stomach", etc. One has to stomach the description of the most horrible crimes committed in great numbers by the starving population of the Volga district of Russia in order to understand the power of hunger. Cases of necrophagia (eating of human corpses) and cannibalism, including killing and eating of own children, were frequent in that region. The description of the mental changes in the perpetrators committed to hospitals or jails is very superficial; the outstanding features of mental dullness, apathy, and indifference reminds one of hypoglycemia (Rosenstein⁴⁴). Hypoglycemia was a regular feature of hunger-edema in the first World War. Despite this we must demand in these cases more definite proofs of hypoglycemia. We know that the normal healthy adult maintains his blood sugar at a certain level by all the means of homeostasis for many days, even if completely deprived of carbohydrates. Besides, the ordinary malnutrition of

the poorer classes and individuals is least likely to be a lack of carbohydrates since bread, potatoes, and cereals are the cheapest foods and least likely to be lacking. However, with all these reservations the well-known problem of the relation of poverty to crime calls for an investigation from the angle of hypoglycemia. In such an investigation we must also keep in mind the possible irreparable anatomical damage and arrest of development in young brains caused by malnutrition in childhood, even if the patient or criminal does not present any metabolic abnormalities at the time of investigation. We do not know at present whether such a diagnosis post factum of sequelae of hypoglycemia in childhood will ever be possible (by means of electroencephalography, psychological tests, etc.).

(2) *Violation of traffic regulations* mostly followed by clashes with policemen or serious accidents is another frequent offense (Heyn²³, Wanchope⁵¹, Marx³⁷). The psychology of this, however, is only partly based on impairment of judgment, sensory perception and motor reaction. It is just as often the effect of the peculiar negativism of the hypoglycemic reminiscent of catatonic negativism. Any order, present or past, by any person in position of authority, such as law, police (Duncan¹², Adlersberg¹), doctors (J. Wilder^{55,58,60}), managers, street car conductors, parents, teachers, are answered immediately and automatically by a negative and defiant attitude. This is in striking contrast to the normal personality of the patient and disappears as if by a touch of a magic wand after the intake of sugar. We can only speculate about the interpretation of this phenomenon in the light of primitive psychology. Is it the "panphobia" (fear of everything) of primitive tribes? Are we dealing here with some form of primitive defense mechanism? Is it a symptom of general irritability? We don't know, but the analogy with the attitude of certain "hard-boiled", especially juvenile offenders, against law and authority is too obvious to be entirely dismissed. There seem to be more problems in the psychology of hypoglycemic traffic violations. Release of simple primitive aggressiveness must be taken into consideration. These patients, children and adults, frequently

bump into other pedestrians (Jones³⁰, Adlersberg and Dolger²) or commit such acts as pushing a woman off the treadle of a trolley car (Henner²²).

This *aggressive tendency* can also be seen in the frequency of violence in any form in clear-cut psychotic as well as other hypoglycemic states (Greenwood¹⁸, Windfeld⁶⁶, Heyn²³). The frequent conflicts in matrimonial relationship arising from attacks of hypoglycemia often contain an element of cruelty and aggressiveness (Jones³⁰, Sonne⁴⁹, Adlersberg and Dolger²). A tendency toward homicidal threats (Sercl⁴⁶, Joltrain²⁹), ideas (Sjögren and Tillgren⁴⁸), or attempts (Kepler and Moersch³⁴), even in children (Anderson³), is frequent, and at least one case of matricide (Hill and Sargent²⁰) has been tried in court. This aggression often manifests itself in destructiveness (Powell⁴², Greenwood¹⁸, Adlersberg and Dolger², Ziskind⁶⁹). Suicidal tendencies (Henner⁴², Wuth⁶⁸, Sjögren and Tillgren⁴⁸) may be the counter-part of this aggression. We find it alarming that aggressiveness and cruelty against children is comparatively frequent (Powell⁴², Ziskind⁶⁹, Greenwood¹⁸, Adlersberg and Dolger², Sigwald⁴⁷). Some examples demonstrate unusual cruelty. An insulin patient observed by Adlersberg and Dolger stuck a pin into her baby's eyes. This problem seems to us serious enough to demand that people with an inclination toward hypoglycemic reactions should not only be prevented from driving cars, but also recognized to be potentially harmful as parents. Since we belong to those who see the best way of prevention of psychoneuroses in the treatment of parents, we may direct our attention to this small, dangerous, and mostly easily preventable group of delinquent parents. Even unmotivated irritability in a hypoglycemic mother is a harmful factor in the training of a child. The lack of understandable motivation in a mother's behavior may easily spoil an otherwise perfect training. J. Wilder raises the question of whether the frequent phobia of mothers of new-born babies—fear that they may stab the baby with a sharp instrument—may not be based on similar emotional experiences. Hypoglycemia is comparatively frequent in nursing mothers and after exertions

such as childbirth. He also raises the question whether some of the frequent unmotivated killings of new-born babies by their mothers may not have been committed in a state of hypoglycemia after childbirth. Among the various behavior problems in children (J. Wilder⁵⁵, Anderson, etc.) temper tantrums, destructiveness, and aggressiveness play a major role.

(3) *Other crimes.* Among other crimes we also find certain trends of behavior. We are not surprised to find lack of tact in the light of our remarks on the disturbances of moral feelings. The tendency to scandalous and disorderly conduct in public (Adlersberg¹, Sigwald⁴⁷, etc.) and exhibitionistic acts (undressing, appearing in the nude, Elias and Goldstein¹³, Oppenheimer⁴⁰) are just as frequent as they are in the manifestations of other, especially schizophrenic, psychoses. The reason for the frequency of exhibitionism does not seem satisfactorily explained; it is tempting, of course, to see in it an act symbolizing return to childhood. Defecating in the living room may be a kindred reaction (Adlersberg and Dolger²). Another trend can be seen in the frequency of *sexual transgression* of any kind (Bower and Beck⁷, J. Wilder⁵⁴, etc.) from tactless attempts at flirting with a nurse to masturbation in public (Powell⁴²), and sadistic acts (Adlersberg and Dolger², J. Wilder⁵⁴) up to sodomy (van Balen⁵). The psychological interest of these cases compared with the analogous behavior of alcoholics lies in the fact that insulin does not stimulate but rather depresses the sexual functions. A case of arson has been recorded (Marx³⁸). Perhaps a case of false fire alarm should be mentioned here (Spaeth⁵⁰). Another group of criminal acts concerns theft, embezzlement, and similar *criminal acts against property*, not connected with sugar hunger. We can understand easily the stealing of sweets (Lichtwitz³⁵), but we do not know the mechanism behind shop lifting (Rud⁴⁵) or other thefts and embezzlement (Menninger³⁹) except in the light of the "moral insanity" to be discussed in the course of this article.

One practically less important yet large group includes *transgressions committed by the spoken word*: blasphemy, pro-

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fane or insulting language, etc. This group, however, may prove in the future to be important for the theory of the hypoglycemic psyche, and indirectly of crime. J. Wilder^{58,60} emphasized long ago that hypoglycemia affects very frequently and early the apparatus of expression and especially the speech. We find on one hand low voice or aphonia, on the other hand megaphonia (speaking with unusually loud voice, inability to whisper); the patients display a tendency to use foreign languages, or they use a sophisticated affected style; or they use, in contrast to their usual behavior, "profanity that would shame an Army sergeant" (Powell⁴², Greenwood¹⁸). The reported case of blasphemy concerned characteristically devout persons (Adlersberg and Dolger²). Sercl's⁴⁶ patient, a Czechoslovak soldier, hailed Hitler and attacked the Jews. These peculiar phenomena in the field of the spoken word demonstrate clearly that we are far from a satisfactory knowledge of both brain physiology and psychology. We can only offer an attempt at an interpretation. We have enough evidence that a purely motor element of sub-cortical type plays a role in the hypoglycemic phenomena including voice and articulation. It is possible that the awareness of those strange changes produces in the patient a desire for rationalization and integration. He interprets his own loud voice as a sign of anger, in the same way as others would interpret it. He may, in the same way, react to this strangeness by the use of a foreign language, affected speech, or blasphemy. We see a similar phenomenon in Parkinsonians who experience conjugated eye muscle spasms, turning their eyes upward, together with accompanying blasphemic thoughts.

ALCOHOL AND HYPOGLYCEMIA

Patients in the state of hypoglycemia have been very often arrested as drunkards (Wanchope⁵¹, Goodhart and Lauder¹⁶, Adlersberg¹, and others). One of Wanchope's patients, a physician involved in an automobile accident, was convicted because the court disbelieved his plea of hypoglycemia. The behavior of the patient, his state of bravado combined with

staggering gait, blurred speech, etc., accounted for this. Sometimes a diabetic in this condition, whose physical examination reveals marks from insulin injections, may be mistaken for a morphinist (Adlersberg¹). We must keep in mind, however, that there exists sometimes a relationship between true alcoholism and hypoglycemia. We have mentioned already the hypoglycemia of "smoke drinkers" due to liver damage. Similar liver damage can be caused by abuse of any kind of alcohol and lead either to hyper- or to hypoglycemia. Nutritional deficiency with depletion of glycogen stores of the liver is sometimes a factor in those cases.

EXAMPLES OF HYPOGLYCEMIC CRIME

It might be necessary to give a little more vivid picture by quoting briefly a few typical cases.

Aggressive acts: One of Adlersberg's¹ patients, a diabetic who had received an insulin injection, felt that he was becoming hypoglycemic but had not sufficient will-power left to eat the piece of sugar he used to carry with him for just such an emergency. He boarded a streetcar and behaved as if intoxicated; he opened his vest, put his hat on in a funny manner, shouted and laughed. A policeman was called at this point but the patient resisted so violently that it took several policemen to drag him to the police station. There he continued to be violent, later calmed down a little, asked for a piece of bread, and became normal within a few minutes after having eaten it. He had complete amnesia for the events reported. Legal action was dropped only after several witnesses testified that the patient had had similar attacks of confusion after insulin in the past. Duncan's¹² patient, feeling ill after an insulin injection, went into a food store and bought some food; however, he collapsed before he could eat it and, believed intoxicated, was thrown out by two attendants; he put up a violent resistance which necessitated the help of the police. A typical case is one by Adlersberg and Dolger². The patient, aware of the incipient attack, went to a candy store; her violent agitation and loud demand for candy aroused the suspicion of

intoxication and the salesman refused to sell her anything, whereupon the usual story ensued of violence, abusive language, resistance against the police, etc.

Examples of homicidal acts and tendencies are illustrated in a case by Kepler and Moersch³⁴ of an individual who, under the influence of insulin, fired a gun at his sleeping brother. A patient of Sjögren and Tillgren⁴⁸ was found sitting upright in bed and pressing a knife against his abdomen; questioned by his wife he threw the knife away, gesticulated, shouted several times: "I shall kill you!" He pushed her aside, ran away, later jumped around wildly, screamed, became confused and threatened the doctor. A case of matricide is described in detail later in this article. A diabetic boy of seven, described by Anderson³, stabbed a child with a knife, killed a drake and threw it into the river, etc. A similar case in a child was reported by Wolf⁶⁷ in spontaneous hypoglycemia.

Instances of torturing of children include such facts as beating a child unmercifully without provocation in a state of spontaneous hypoglycemia (Ziskind and Bailey⁶⁹), or the case of a devoted mother who stuck a pin into her baby's eye several times and then strangled it (Adlersberg and Dolger²).

Concerning the frequent traffic violations it might be interesting to read the self-observation of a physician in a state of spontaneous hypoglycemia (Marx³⁸): "I woke up at 3:30 P.M. completely rested, felt marked hunger but postponed eating anything since I had an invitation for tea one hour later. While smoking a cigar I had at times a faint feeling and left with my car around 4:30. I remember clearly the first five minutes of that trip, then there is a gap in my memory for about five minutes after which I recall again my companion grasping my arm and asking where I was going. I got frightened, stopped the car and found out that I had driven in a planless and aimless manner through the city in a direction opposite to my goal. . . . My companion was struck by my driving with fixed gaze straight in the opposite direction. . . . I noticed ravenous hunger, marked fine tremor of my fingers and coarse tremor of my arms, profuse perspiration of the

entire body, especially face, also the hairy part of my head, extreme muscular weakness. . . . After two cups of tea with plenty of sugar the symptoms disappeared within a few minutes."

Typical offenses are driving against the traffic lights, running heedlessly through fast moving traffic, ramming lamp posts or stationary vehicles, etc.; this is often followed by violent arguments, or fights with the traffic policeman.

Except for police action, few cases until now have been tried in court. Or to be correct, only on a few occasions has spontaneous hypoglycemia been *suspected* or *acknowledged* as an important factor in the commission of criminal acts. It is fair to predict that such cases will be more frequent in the future. Among them was a case of arson described by Marx³⁸; an act of arson was committed in a peculiar automatic state observed by witnesses; similar automatic behavior could be reproduced by injection of insulin. In the case of a 33 year old man who murdered and mutilated his maid, hypoglycemia could be evidenced in the dextrose tolerance test; the blood sugar went down in the fourth hour to 42 mgm. per cent and remained on this level; hypoglycemia was accepted by the court as a mitigating circumstance (Dr. William Wolf of New York City, personal communication).

A CASE OF MATRICIDE IN A STATE OF SPONTANEOUS HYPOGLYCEMIA

One of the best investigated subjects ever tried in court, acquitted after the connection between his crime and hypoglycemia could be satisfactorily proved, may for the time being serve as a model case. It was published by Hill and Sargant in 1943²⁰.

A twenty year old man, living alone with his mother, stabbed her to death with a kitchen knife; many wounds were found on her body. In the five days preceding the murder, he had worked hard and had had but irregular meals; besides, there had been some quarreling with his mother over money. On the morning of the day of the murder he struck her, a very

unusual act for which he apologized. He ate very poorly on that day. He had his last carbohydrate meal at noon. Between 9 and 10:30 P.M. he drank four pints of mild ale. At 11 P.M. there was again a quarrel with his mother over money and she pushed him out of her room. At this moment he suddenly felt thirsty, went to the kitchen to get a bottle opener, saw a kitchen knife, and then "something came over" him: "I was like a homicidal maniac." He stabbed his mother to death, then realized what he had done, wiped the knife for fingerprints, washed and dressed, and left the house. There is a gap in his memory for seven hours following the crime. The next day, he gave himself up to the police and made a full statement.

The psychiatrist working over this case may already have noted the poor motivation and the violence of the crime; the discrepancy with the usual personality of the patient; the fact that he readily recalled all incriminating details of the crime but did not recall what happened in the seven hours following the crime. These doubts were confirmed by some evidence that the seemingly complete description of the crime was not so complete after all: a witness for the prosecution, a neighbor, testified that he heard screams at the time of the crime, yet the patient, despite all the details he gave, did not recall these screams.

After the patient's arrest, his family physician notified the defense that two years prior to the crime a sugar tolerance curve had shown a tendency to hypoglycemia (56 mgm. per cent three hours after ingestion of sugar).

The patient looked undernourished and gained five pounds in the six weeks in prison while awaiting trial.

He showed a number of neuropsychiatric abnormalities: bilateral nerve deafness, equivocal plantar response on the left side, history of motor incoordination up to the age of nine. His personality was not quite normal; he had always been nervous and apprehensive, unstable, dependent upon his mother, emotionally immature, but not dishonest and not ag-

gressive. He showed little emotional reaction to the whole incident.

In order to investigate the possible connection with hypoglycemia, the authors performed a number of tests, of which we mention the following:

(1) After 50 gm. of glucose, the blood sugar rose from 83 to 147 mgm. percent in half an hour and then fell to 72-78 mgm. percent for the next four hours. This is only a very slight anomaly.

(2) The electroencephalogram showed, however, that at blood sugar levels below 100 mgm. percent the usually normal electroencephalogram became abnormal: it showed a 4-6 cycle abnormal rhythm, pathological instability on hyperventilation, and asymmetry between the two hemispheres. This anomaly became gradually more intense with the progressive lowering of the blood sugar. When hyperventilated with low blood sugar level and 3 cycle rhythms in the electroencephalograms, there was definite evidence of impairment of consciousness.

(3) To rule out the influence of alcohol and the malt in the beer drunk prior to the crime, tests were made which proved that the beer had but slight influence on the psyche, blood sugar and electroencephalogram.

The authors expressed the opinion that the patient's blood sugar at the time of the crime must have been below 100 mgm. percent; that his brain at that time was functioning abnormally; and that his judgment was impaired at the time. The verdict was: "Guilty but insane".

This case is noteworthy because of the fact that the mental changes typical of hypoglycemia occurred at comparatively high levels of blood sugar. J. Wilder⁵⁴ describes a case of a patient with high fasting level of blood sugar in whom typical hypoglycemic symptoms, reversible by sugar, started at levels slightly above normal. We know such phenomena in diabetics.

EXCITEMENT AND HYPOGLYCEMIA

The relationship between excitement and hypoglycemia is of great importance. Impulsive crimes, the sort we are deal-

ing with here, are often committed in a state of excitement (*crime passionel* of the French authors). It is not always easy to say whether the excitement was adequate to the cause or not. The hypoglycemic impulsive crime is also committed in an excited state. It is, therefore, important to discuss the relationship between mental excitement and crime.

We know from the experiments of Cannon and others that fear and anger as a rule cause a rise in blood sugar due to increased adrenalin secretion. We can actually say that hypoglycemia is the only disease which is helped by mental excitation. J. Wilder^{56, 57} reports several examples of that kind: a patient suffering from severe chronic hypoglycemia was cured for a period of two months following the death of a sister with whom she had lived; when her brother, who lived in a different city, died she was not improved. On the other hand, hypoglycemia *per se* causes an excited behavior, making it sometimes difficult to distinguish between cause and effect. It is quite possible, as Duncan says¹², that the mental excitement caused by hypoglycemia in turn causes a self-reparatory adrenalin secretion.

Whether or not we have the opportunity to observe a hypoglycemic criminal in the state of hypoglycemia, we may notice a number of symptoms which deviate from the normal somatic effects of excitement, *e.g.*, slowing of pulse rate or positive Babinski's sign.

To add to the difficulties, excitement may, under special circumstances, cause hypoglycemia instead of correcting it. In our experience this applies to a combination of repeated excitements within a short period of time, combined with insufficient intake of carbohydrates. These repeated excitements, just like repeated injections of adrenalin or thyroxin, mobilize the glycogen stores, transforming glycogen into glucose, and deplete them. If the subsequent supply of carbohydrates does not replenish them, the ground is laid for hypoglycemia. It is, therefore, very important in a case of an impulsive criminal act to obtain the history of food intake prior to the act. Abundant intake of carbohydrates makes hypoglycemia very

improbable, although we may keep in mind disturbances of gastrointestinal resorption caused by excitement. On the other hand, a history of prolonged starvation or malnutrition prior to the crime is suspicious. By experiment we may then reconstruct the vicious circle: repeated excitements—neglect of eating and drinking — hypoglycemia — hypoglycemic excitement with impaired metabolic equilibrium due to depletion of reserves of carbohydrates.

PSYCHOLOGY OF HYPOGLYCEMIA AND PSYCHOLOGY OF CRIME

Much further study will be necessary until we shall really understand the psychological link between hypoglycemia and crime. In the end, both disciplines, criminology as well as brain physiology, will benefit from such studies. We have tried to describe those mental changes in hypoglycemia which fit into the medico-legal concepts of "impairment of judgment" and "impairment of self-control". We all presume that the previous personality of the patient is a decisive factor in determining his individual hypoglycemic mental phenomena. However, we must admit that until now the efforts to prove this thesis have not yielded any conclusive results. For practical purposes it is even better to keep in mind that the first suspicion of hypoglycemia will often arise because of the striking discrepancy between the behavior of the patient during the attack and his usual personality. The patients speak of themselves sometimes as Dr. Jekyll and Mr. Hyde.

The concept of a special impairment of an assumed "moral sense" leading to a special "moral insanity" played a role in the older literature. It has been given up recently, despite the fact that the observation made in the last decades on post-encephalitic children should rather have increased the interest in this viewpoint. Children with severe personality disorders who, due to their special form of antisocial behavior create a difficult problem even for closed institutions, are sometimes, for lack of proper nomenclature, classified simply as "behavior problems". Just as in these post-encephalitic children and in certain psychopaths the question arises in our hypoglycemic

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patients as to whether the concept of moral insanity was not a useful concept after all despite its abuse in the courtroom. The interesting point is that we may have, in a hypoglycemic state, a spell of "moral insanity" which can be produced and removed at will and thus be studied experimentally. Thus a patient of Adlersberg and Dolger² used to develop, in a state of hypoglycemia, bizarre sadistic tendencies which were followed either by amnesia or by deep shame and embarrassment. Wiedeking⁵³ describes a hypoglycemic state in a normal person caused by experimental insulin injection. The tested person stated that she remembers having had a certain thought that normally would have been embarrassing to her since it concerned a forgotten obligation; yet during the attack she noticed that she had lost any distinct sensation of compunction in having this thought.

If we mention a few of the psychologic traits of hypoglycemia, we shall see immediately that they are at the same time traits important in the psychology of delinquents, especially juvenile and defective delinquents: impairment of will-power, hazy thinking, loss of associations, impairment of moral sense, "concrete behavior" and impairment of abstractive thinking, irritability, negativism, strengthening of aggressive and sexual drives, imperative hunger, etc. Of all these features, the early loss of spontaneity and initiative seems to be the most interesting feature in the psychology of hypoglycemia. Correctional medicine, on the other hand, seems to emphasize the same feature in delinquents since development of the sense of responsibility and initiative plays such a role in the modern approach to the readjustment of juvenile delinquents. Hypoglycemia offers here the unusual opportunity of experimentation in criminology.

SUGAR METABOLISM OF DELINQUENTS

The first attempts in this direction have been^o made in the form of the study of nutrition and fasting blood sugar in groups of delinquents. Rojas and Sanchi⁴³ in Buenos Aires have examined the blood sugar in 129 delinquents shortly after

their apprehension; they were mostly juveniles and the offenses were in 32 cases against persons, 65 against property, 10 sex offenses, etc. In 48 cases the blood sugar was less than 75 mgm. percent, in one even as low as 38 mgm. percent, and in 64 cases between 75-90 mgm. percent. Only in 13 cases was the blood sugar strictly within the normal limits of 90-110 mgm. per cent.

That criminality is much higher among the poor has always been known, and so is mental deficiency. Burton⁹, *e.g.*, found in London in 1935 in "better neighborhoods" about 1 percent, in poorer districts about 20 percent, of dull children. Improper nutrition is more often a factor than quantitatively insufficient food. In New York State (1945) Church¹⁰ found evidences of undernutrition or malnutrition in not less than 80 percent of 750 boys admitted to an institution for juvenile delinquents. He says: "Delinquent children crave food, steal money for it, and ingest it rapidly. They hide food in institutions when they are assured of 'three squares'. They talk about food as much as, if not more than, they do about 'Superman'. The delinquent child's mode of ingestion leads to a peculiarly high figure for abdominal complaints."

On the other hand, Kelly³³, in studying dietary deficiencies in 225 patients from the upper income brackets found carbohydrate deficiency in 88 per cent, proteins deficient in only 36.5 per cent, and no cases of fat deficiency. He emphasizes the frequency of clinical symptoms of hypoglycemia in the dextrose tolerance test in this group.

THE DIAGNOSIS OF HYPOGLYCEMIA IN CRIMINOLOGY

The first suspicion of hypoglycemia will arise when we hear that the criminal offense does not seem psychologically well motivated, or when there is amnesia for either the whole incident or for single details, or for the time prior to the incident. We shall have it in mind if physical symptoms like striking perspiration, tremor or other symptoms of hypoglycemia accompany or follow the incident, *e.g.*, deep sleep. We shall always keep in mind this possibility if we are dealing

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with a diabetic, whether he receives insulin or not, or with a non-diabetic treated with insulin, or with a person known to suffer from a condition frequently accompanied by hypoglycemia, *e.g.*, a liver disease or endocrine disorder. We should also think of hypoglycemia in undernourished as well as in abnormally fat individuals, or in cases which present a history of chronic malnutrition, acute starvation, diarrheas or vomiting prior to the crime.

In order to ascertain whether our suspicion is correct, we can use a number of tests:

(1) Fasting blood sugar at rest and after muscular exertion, if there is a history of such exertion prior to the crime. However, the value obtained may be too high due to excitement in the first days of hospitalization or imprisonment.

(2) Blood sugar tolerance curve at rest; this should be extended over 5-6 hours since there are cases who develop deep hypoglycemia only at that time. It is also important that a standard diet, neither too rich nor too poor in carbohydrates, be given for at least three days prior to the test (Conn¹¹).

(3) Insulin blood sugar curve.

(4) Reproduction of the mental state at the time of the crime by insulin or starvation with careful psychiatric observation, especially for amnesia and, if necessary, identification of this behavior of the patient by witnesses of the crime; the conclusion of the experiment by the observation of the psychological effect of glucose injection or ingestion is most important.

(5) We may follow all these experiments by electroencephalographic studies.

(6) Should the delinquent develop any state of excitement or peculiar behavior while in jail or hospital, a blood sugar test should be made in this state, followed by observation of the effect of sugar.

(7) Application of the same diet as the one the patient had in the days preceding the crime with simultaneous blood

sugar tests and psychiatric observation might be necessary in certain cases.

(8) A thorough internal, endocrinological and neurological examination should be mandatory.

THERAPY

Since the hypoglycemia may be due to a number of conditions, a thorough internal, endocrinological, and neurological study is necessary in order to determine a causal therapy wherever this is possible (*e.g.*, treatment of the liver disease or surgical removal of a pancreatic adenoma, etc.). Where such treatment is impossible, a proper dietary regime has to be instituted according to the peculiarities of the individual case. We must refer to the medical literature on this point and wish only to emphasize that many cases are benefited, paradoxically, by a diet rich in fat and very poor in carbohydrates, while others require large amounts of carbohydrates.

It is very important to keep in mind that our knowledge is not sufficient at present to determine in the individual case whether *permanent neurological and psychiatric changes* on an anatomical basis, if present, are due to recent or past severe chronic or repeated hypoglycemia. We are also unable to tell in advance whether they are reversible, or not. Therefore, every case presenting constant mental impairment and suspect for present or past hypoglycemia should be given the chance of prolonged carbohydrate feeding for many months. Powell⁴², J. Wilder^{55, 56} and others, have described cases in which psychosis or mental deficiency of long standing were completely removed by an abundant supply of sugar. It is important to keep in mind that such a diet requires balancing of the rest of the diet, especially high doses of vitamin B₁.

In concluding this chapter, we wish to emphasize that we are probably standing here at a beginning rather than at an end of a new scientific approach to the problem of crime, and that many and careful investigations will be necessary in order to establish the proper place of this problem within the framework of criminology and correctional medicine.

SUGAR METABOLISM IN ITS RELATION TO CRIMINOLOGY

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PREINSTITUTIONAL RECOGNITION AND MANAGEMENT OF THE POTENTIAL DELINQUENT

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In order to be able to recognize incipient delinquency and to plan for its prevention through wise management of the prospective delinquent, it is vitally necessary to understand something of the basic causes underlying it and the most successful means of overcoming them.

Since, technically speaking, the term delinquency, which includes misdeeds, faults, and numerous types of misbehavior (among them truancy, larceny, sex offenses, incorrigibility, personal violence, and destruction of property), is applied only to the offenses of young people under sixteen or eighteen and includes all offenses committed by them, the subject will be discussed largely from the adolescent standpoint.

The problems of juvenile delinquency spread themselves all over the community life. They have to do with preparing young married couples for the responsibilities of parenthood—with the training of children from the nursery up through adolescence. They include sociological, educational, recreational, and economic questions. All the aspects of community entertainment demand consideration — movies, playgrounds, parks, skating rinks, dance halls, pool rooms, bowling alleys, and all other public activities with which children and youths come in contact, not excepting the literature and radio programs to which they have access. And not the least of the influences concerned with the prevention or stimulation of juvenile crime is the religious atmosphere of the community.

Society is certainly falling down on the job. In the face of the lessening influence of the home and of religious authority, young people grow up viewing a panorama of broken and loveless homes, orphan asylums, juvenile courts, jails, and prisons, all vivid testimony to society's failures. With this

confusion and social breakdown, it is not strange that restless and adventurous youths attempt to solve their own problems, and that in this experiment they often become delinquent through tampering with alcohol, sex, and crime.

It would be of untold value to the young people of every community if its responsible adults—fathers, mothers, teachers, clergymen, physicians, editors, and officers of the law—could be instructed through mental-hygiene classes, conducted under the supervision of recognized authorities in this field, in the fundamentals of the training of young minds in wise reactions to the constantly recurring problems of everyday living. Young folks are profoundly influenced by the attitudes and actions of the older members of society, to whom they naturally look for instruction and example, but when these older folks lack the necessary knowledge and practical experience, when the youngsters are left to blunder along by trial-and-error methods, is it any wonder that youthful delinquency is becoming such a serious problem? How much more sensible and economically sound it would be to devote to such preventive education of adults a part of the funds that are regularly spent on the apprehension, trial, and incarceration of delinquent youths? Probably no expenditure of public money would pay such handsome dividends. And this is saying nothing of the indirect loss to society of the productive possibilities of the young people who would be rescued from lives of crime for worthwhile careers.

A practical demonstration of such a program of adult education has been made by the W. K. Kellogg Foundation in seven counties in southern Michigan. Under its auspices the author conducted mental-hygiene courses over periods of one and two weeks with the following groups: physicians, clergymen, editors, probate judges and prosecuting attorneys, county supervisors, public health nurses, mothers, and fathers. These courses were supplemented by public mass meetings and lectures to special organizations. During the summer vacations several hundred public school teachers were sent away to various universities for special work. The mental-hygiene

program, as it concerns teachers, was set up with the idea of correlating such training with these regular summer-school courses, and care was exercised to see that those who taught mental hygiene were not too far removed in spirit and purpose from the general mental-hygiene activities of the Foundation.

On the completion of this program we felt that we had at last covered the entire field, and that we had been able to make a very close approach to the child himself in the *home*, where mental hygiene, if it is to do real preventive work, must very largely accomplish its task during the preschool years. When the child is old enough to go to school, mental hygiene is chiefly a matter of remedial and corrective work, re-education.

ATTITUDES AND CHARACTERISTICS OF THE ADOLESCENT DELINQUENT

Unfortunately, preadolescents have the idea that gang leaders, whether of their own ages or among adult gangsters, are public enemies Nos. 1, 2, or 3, and in their inexperienced minds they associate a certain distinction with such reputations. Children and youths crave attention and thrive under it, whether it is bestowed upon them for worthy or unworthy conduct. Adolescents are cocky, and when arrested for some offense, instead of being admonished against a repetition of their criminal acts, they very quickly reach the conclusion that they are smart enough so to profit by this experience as to avoid further arrests.

Delinquent Types. There is a peculiar type of mental and emotional "set," or trend, which characterizes many adolescent delinquents. It is impossible to say just how much of this is inherited and how much is due to environmental training, but most of it is probably socially acquired. *Delinquent boys*, as compared with the nondelinquent, are more pronounced in their likes and dislikes, and their emotions are more unstable. As a rule they have few friends and are not very communicative. They are introspective and frequently prefer to be alone. They take things concerning themselves seriously and

are often pretty well convinced that they are "no good," that they are not going to amount to much anyway, and that it matters little what they do with themselves.

It appears that *delinquent girls* differ less from the normal than do wayward boys, though it does seem that the girl has the notion that she is inferior intellectually and socially; she is also reticent. Delinquent girls are inordinate daydreamers, but on the whole, the incorrigible young woman (when not feeble-minded or retarded intellectually) is not very different from her normal sisters.

Most Delinquents Intelligent. In general, the higher the intelligence of adolescents, the more trouble they are likely to have with maladjustment, mental conflicts, emotional mix-ups, and delinquency. Very intelligent young folks not only possess a greater potential for anxiety and worry, but they are much more likely to be restless and adventurous, and their active imaginations conjure up many ways of attempting to escape from their dilemmas by means and methods of which society disapproves. It is a fact that large numbers of mental defectives and dullards do not become criminals, while on the other hand a great many youths from highly respectable families are each year arrested and convicted for crime. Investigations have repeatedly disclosed that from two-thirds to three-quarters of juvenile criminals possess normal or supernormal intelligence. More than half of the inmates of the state prisons of this country are normal-minded individuals.

School Experience of Delinquents. The majority of delinquents stop their schooling in the upper grades of grammar school. The Gluecks reported that out of 1,000 juvenile offenders, only 96 ever attended high school, and that only 28 were going to high school when first arrested. It therefore appears that delinquency is uncommon among youths who enter high school, and that it decreases with each year they continue their educational programs.

Another interesting observation is that juvenile criminals exhibit a far greater degree of *educational retardation* than

mental retardation. Many a delinquent adolescent has normal social capacity, although some are reticent, introspective, and seclusive. They often make friends easily and display numerous qualities of leadership.

Personality of Delinquents. There are many reasons for believing that the personalities of delinquent adolescents are not well organized. That they are *poorly integrated* is proved by their tendency to allow isolated occurrences to occupy too great a place in their consciousness. Normal youths would be likely to relate any given situation with past experiences and to evaluate it in the light of its possible effect on their future standing in the community, but the delinquent seems to have a narrowed field of consciousness and to be unable to do this. He is looking for the *immediate satisfaction* of what he thinks is his present need. His temptation to commit a crime is an isolated situation, having in his mind little or no relation to his life as a whole. This is evidenced by the fact that, when young criminals are asked why they have committed a misdemeanor, they so often reply: "I don't know why I did it. I guess I didn't think," or, "Well, I wanted it and I just took it." They frankly admit that they knew it was wrong to commit the crime, but they just went ahead and did it anyway.

CAUSES OF DELINQUENCY

It is a sad commentary on modern civilization that delinquency and crime are most prevalent in the adolescent age group. Such misbehavior may be a reflection of the so-called "restless age," but it is more likely due to the adolescents' dawning appreciation of the fact that parents and other adults are guilty of much questionable conduct. They discover a great difference between the morals taught them by their elders and the actual lives these elders live, so that it is perhaps not strange that during this period of emotional conflict and inexperience many youths become involved in various forms of antisocial behavior. Adolescents hear and read about *political skulduggery*, tax evasions, and numerous other offenses against society, and early discover that but few of the

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perpetrators of such misdeeds are brought to trial, and that still fewer are ever convicted. If parents make light of traffic laws and other civic regulations, it is not to be wondered at that inexperienced and adventurous young people are lured into committing the types of crime which appeal to adolescents.

Bad heredity, defective intelligence, emotional instability, hypersuggestibility, home and neighborhood conditions, psychopathic personalities, constitutional inferiority, immaturity, emotional conflicts, and endocrine disturbances have all been suggested by various writers as causes of adolescent delinquency.

Heredity figures most prominently in the causes of crime through the production of feeble-mindedness and the lessening of emotional inhibition. Many factors of inheritance cannot be modified by the subsequent environment; on the other hand, certain of them can be. Hereditary traits often are not in evidence at birth or early babyhood; so their later appearance is assigned to the influence of environment. At the same time, many nefarious traits never appear in actual life because of the counteracting influences of a good environment.

Inherited Qualities. While the sociologist tells us that crime grows out of a faulty environment, the fact remains that in many undesirable, even broken and loveless homes, some of the children become delinquent while others escape their environment and become respectable citizens. The environment is the same but the heredity is different. True, as someone has remarked, this very difference of inheritance causes these superior children to create a new and better environment for themselves in the very midst of the unfavorable home situation. In other words, a home which would be typical for breeding crime because one or both of the parents are inferior, immoral, and antisocial, will make a criminal only out of the child who tends to resemble his parents. In this connection it is interesting to note that Hirsch, in his Detroit investigation of the causes of delinquency, showed that 48 per cent of the children of the families studied turned delinquent, whereas 52 per cent did not.

Family Influence. A youngster growing up in primitive society found himself the member of a family unit functioning in a community where there was uniformity of opinion regarding things social, religious, and political. He readily became a part of such a community of interests and therefore suffered very little confusion in his mental and emotional life. Today, adolescents grow up in towns and cities in which there is a continuous clash of opinions and conflict of views, and they are bewildered by the endless profusion of beliefs and attitudes. No wonder modern adolescents are predisposed to neuroticism, maladjustment, and delinquency!

Family Loyalty and Security. Normally a youth should belong to a family which affords him the satisfaction of security, and to which he can become thrillingly loyal. If he chances to be growing up in a loveless home, his feelings of insecurity will increase until he is possessed with a sense of isolation and loneliness; *impulses of recklessness* and ruthlessness are sure to grow out of this feeling. Such a state of mind and emotions is readily relieved by some type of delinquency. The adventure of crime is an antidote for his loneliness, insecurity, and unhappiness. The planning and execution of his crimes provide *excitement* and exhilaration, and he is thrilled with the formulation of his plans to prevent detection. Not only that, but his sense of social isolation is overcome by becoming a member of a predatory gang; at last he belongs to a crowd which provides him with the satisfactions of camaraderie and of being loyal to a group.

Adolescent criminals are not all recruited from the slums. Many cases of juvenile crime come from cultured homes of high social standing, albeit careful investigation often discloses that the emotional atmosphere in these supposedly good homes is not very satisfactory. In many cases the children have simply been allowed to "grow up" with very little or no real social training and moral guidance.

The Family Honor. A reason why adolescents repeat their delinquencies is that they quickly learn that parents are

willing to rush to their rescue, and that they will do almost anything—compromise, pay, cover up—in order to protect the family's good name.

"Getting Even." Many boy and girls grow up to adolescence consciously or unconsciously suffering from a sense of deprivation. They feel they have been cheated out of the love and security they should have had. There is a good deal of *jealousy*, too, of other members of the family, and all this frequently results in a growing bitterness, a craving for revenge, which slowly takes possession of them. No wonder that, when temptation comes, they yield to some impulse to commit a crime, not only for adventure, but because it offers a way of getting even with parents, with teachers, with adults in general—with society.

Delinquent Environment. What might be called a "delinquent environment" consists of loveless homes or homes in which the discipline is ineffective, of poverty-stricken homes, and of homes where the morality of parents is questionable. Social workers and probation officers have thought the broken home to be one of the chief explanations for crime, but the studies of Shaw and McKay³ suggest that this is not true of juvenile delinquency. In Chicago they found that Mexicans, with a high rate of broken homes, had a low rate of juvenile delinquency. On the other hand, Italians, with a lower rate of broken homes, had a high rate of delinquency.

Hirsch, in reporting on his Detroit studies, took into account the different types of broken homes but finally concluded that it is more likely the *loveless home*, rather than the broken one, that causes delinquency.¹

In addition to such home environment, the neighborhood atmosphere is likely to be hostile to the normal development of children; there is not sufficient opportunity for social activities and wholesome outdoor play. "Delinquent schools," of which there are some, as a rule are closely associated with *delinquent communities*. The rigid, theoretical curriculum of the public school makes it difficult for non-bookish, non-ac-

demical youngsters to get along well. There are too few opportunities to learn about practical living. The final blunder of society is its failure to provide school activities that will interest and intrigue these peculiar types of youths who are likely to turn delinquent when frustrated, disappointed, and discouraged.

Idleness has a most serious influence on delinquency. Long summer vacations in a large city, especially in its slum districts, are crime-breeders. It is to be hoped that some day more city children can enjoy camp life or some other form of outdoor country living during the summer months.

Monotony is unbearable to adventurous youths. They crave excitement, and they are going to get it some way. Very much in modern life, from amusements to automobiles and literature, tends to create a spirit of emotional and social restlessness; when legitimate means for securing thrills and gratifying the love of adventure are not provided, certain adolescents are sure to turn to crime, which explains why their homes do not necessarily have to be broken, loveless, or immoral. Those which are dull and monotonous also make it more likely that their juvenile members will become delinquent. Crime, like alcohol and sexual excesses, tends to antidote unhappiness and temporarily to relieve ennui. Many times juvenile crime is nothing more nor less than an unconscious attempt to escape boredom.

Emotional Factors. All of the more recent studies point to the conclusion that it is largely in the field of emotional disturbance that we must look for the causes of juvenile delinquency. We talk about underprivileged children and broken homes, heredity and environment, playgrounds and criminal neighborhoods, but the basic cause is failure to gain emotional satisfaction or a struggle with unsolvable emotional conflicts. Disappointment and frustration constitute the background of juvenile delinquency.

Emotional Maladjustment. No wonder our present-day methods of dealing with crime are futile. To our youth we

have stressed the importance of physical health, mental training, moral education, and socialization, but all our efforts at preparing them for citizenship have failed to take into account the fact that the emotions are the dominant and all-powerful factor in determining human conduct. Juvenile crime, as it is becoming better understood, seems to present the simple problem of youths' seeking for happiness, for emotional satisfaction. Why they turn to crime in an effort to compensate for a dull, drab, and unhappy existence is not easy to explain. I probably has something to do with the organization of present-day society; their course of behavior is perhaps more definitely influenced by the ideas and ideals which characterize the modern mechanistic and materialistic social order.

Delinquent behavior is a symptom, a type, of the adolescent's reaction to his environment. Not often is his delinquency chargeable to neuroticism, defective mentality, or psychopathic personality. The quarter-million children who go through the juvenile courts of this country annually are, roughly speaking, average to fairly normal.

Seeking the Limelight. Adolescents have a passion for the limelight. They thrill to the adventure of turning in false fire alarms and of getting the newspapers and police stirred up to detect the culprits. They enormously enjoy feeling that they are causing such a disturbance, and even when they are caught in their petty crimes, they enjoy the front-page notoriety; publicity makes a hero out of a criminal in his own eyes as well as in the eyes of his gang.

Thrill Craving. It is never possible to predict in what direction this craving for thrills will break out. In one case it will be fire-setting, in another stealing, in another a sexual escapade. Linked with all of this is the will-to-power, on the one hand, and the attempt to compensate for a real or fancied inferiority, on the other. Some young girls are merely giving vent to exuberant youthful spirits, or trying to satisfy the urges of unusually aggressive personalities.

Emotional instability is one of the chief factors in juvenile

crime; and this—combined with envy and jealousy, rebellion against authority, lack of high ideals, bad home influence, and poverty—when hooked up with a desire for notoriety, perfectly sets the stage for juvenile delinquency.

Personality maladjustment in boys is also often associated with unwise attempts at self-support, including early cases of stealing, begging, peddling without a license, and violation of truancy laws; also belonging in this category are such offenses as incorrigibility, including running away from home, and other conduct due to the failure of parents to wean their offspring psychologically.

Certain hereditarily unstable borderline cases, if they fail "to find themselves" on entering adolescence, stand in grave danger of losing control of their mental operations because of inefficient preadolescent training. Many of these young people belong to the dementia praecox group and later develop full-fledged insanity. If they have been so trained psychologically that they cannot stand the stress and strain of looking for a job, meeting competition, and taking the inevitable rebuffs, they may attempt to *retreat from reality*; or they may resort to some form of neurotic semi-invalidism, delinquency, insanity, or even suicide, which, however, is attempted rarely and then only by highly unbalanced individuals.

Various Causes. Among the miscellaneous causes of adolescent delinquency the following may be mentioned:

1. *Accidental* causes include disease, such as meningitis or infantile paralysis, the loss of parents, and accidents and injuries, all of which are quite beyond human control.

2. *Genius*, or what might be called leadership, has a great influence upon any community or any one generation of human beings. Today there is abroad in the land a marked spirit of unrest which is especially prevalent among young people. If sound leadership is not provided, if there is not a sufficient number of geniuses and heroes to guide these turbulent youngsters wisely, they are quite likely to turn to gambling, alcohol, sex offenses, and other types of juvenile crime.

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3. *Multiple Causes.* One thing we can be sure of—as a rule crimes are not due to any one single influence. A combination of causes may lead one youth to commit a crime of one sort and another to do something entirely different. Remember that these young criminals are seeking relief from some abnormal feeling or tension. They are trying to satisfy some bedeviling drive. Maybe they feel inadequate and inferior and want to prove their courage by committing a crime. Maybe they think society has mistreated or ignored them, and they want to get even; and, of course, there are always lurking about in the taverns, pool-rooms, and public parks older agents of crime who are looking for youngsters whom they can use as cat's-paws.

A flood of *new emotions* is charging through the adolescent's mind. He craves independence. He longs for thrills and excitement, and when bored with monotony and suffering from frustration and disappointment, he readily turns to the adventures of crime, which explains why 40 per cent of our criminals are adolescents, and why the ranking age for law-breakers is 19 years.

4. *Different Viewpoints.* And so the eugenicist tells us that crime is largely due to defective germ plasm; the euthenicist says it results from poor environment, bad housing, lack of play-grounds; the physiologist suspects ductless-gland trouble; the psychiatrist points to mental conflicts and maladjustments; the educator says our inadequate school system is at fault; the physician thinks there is something wrong with the body itself; the religious teacher blames lack of religious training and moral education.

SEX AND DELINQUENCY

While the young folks of today have had more sex instruction than those of former generations, there has been a paucity of *sex interpretation*. Increased sex instruction has done much to lessen sex worries and anxiety, but it has done little, if anything, to improve sexual morals. There is just about as much of the sex element in juvenile delinquency today

as a generation ago. It represents one of the major divisions of juvenile crime; in fact, among girls it is the outstanding delinquency.

Sex Offenses and Stealing. There are a great many cases in which stealing and sex delinquency are practiced alternately as relief for nervous tension and social restlessness. Many times sex offenses are committed by young people for the same reason that they resort to the use of alcohol—to convince themselves and others that they have “grown up.”

These abnormal sex drives are also exhibited by “rippers” and “slashers,” those boys who cut pieces of clothing from girls’ dresses or snip off locks of their hair. Many times these sexual delinquents are intelligent youths, good students, and otherwise very well behaved socially.

Sex and Psychosis. Undoubtedly many sexual delinquents are on the borderline of insanity. This will explain certain types of sex perversion, criminal sexual assaults, and chronic exhibitionism. This group of psychotic sex offenders will not be helped very much by ordinary methods of treatment. They should be adjudged insane and properly confined. Certain types of epileptics and psychopathic personalities should also be included in this category.

And now, with these manifold causes of youthful delinquency before them, it is possible for, and the bounden duty of, parents, teachers, physicians, municipal and court authorities to be on the lookout for the appearance of the preliminary signs of delinquency in the reactions of adolescents who are subjected to these causes of transgression. The close co-operation of these responsible members of the community will enable them to detect the early indications of tendencies on the part of young people to stray from the path of rectitude and, by being thus forewarned, to take the necessary steps to prevent their plunge into lives of crime.

PREVENTION AND CORRECTION OF DELINQUENCY

There can be no question that society’s ignorance and lack of concern regarding juvenile crime have had much to do with

its increase. Sooner or later we must recognize that crime is a reaction of the entire personality, and eventually we must concern ourselves more with the delinquent than with his delinquency. In his behavior he is but exhibiting a reaction of himself, which embraces not only his heredity but also his intelligence, education, and home training.

All of our approved and most up-to-date methods of treating the juvenile delinquent have failed. In fact, our handling of criminals of all ages seems to be more or less ineffective. Something must be done to develop a *technic of prevention*, and to this end a beginning has already been made of studying the criminal himself.

The prevention of juvenile delinquency has to do, first, with trying to cure those who have already gone wrong and, second, with preventing the still younger group from becoming delinquent. The reason why all methods of cure have failed is that we do not begin to apply corrective measures until the young criminal makes his first official appearance in court, and by that time he is already a confirmed delinquent, often having been a *problem child* from nursery days.

The Psychiatric Diagnosis. In all our efforts to prevent crime, the thing of first importance is the diagnosis. The feeble-minded, the hopelessly maladjusted, the epileptoid and psychopathic personalities, and the definitely psychotic types of adolescents are not going to be helped by any known methods of treatment. There is a borderline type of youngster who can be helped if unwholesome home and neighborhood environments could be overcome.² A third group offers much promise if given proper treatment. The chief trouble here is emotional frustration or conflict; in these cases, patient and intelligent training, with proper discipline and modified educational programs, will yield astonishingly good results.

Early Training. When it develops, no matter at what age, that a child is becoming a social problem, is gradually and increasingly manifesting the potentials of delinquency, he must be taken in hand and subjected to kind, firm, and understand-

ing discipline. He must be taught social adjustment, how to compete with the group, how to be happy though at times more or less inhibited.

Preventive Schools. The tendencies of delinquency, being so largely emotional, must be corrected in the home and the school; and since the homes of potentially wayward youths are usually badly maladjusted, the school seems to offer the only possible means for the effective prevention of juvenile crime. This will necessitate special schools, schools that can supervise the child's every waking moment. He will eat, play, study, and live at school. Some type of detentional educational and training institution must be created which will keep potential delinquents away from their homes and neighborhoods. The curricula of such schools, while giving reasonable attention to ordinary subjects, will be principally concerned with emotional, social, and manual training. No other plan of prevention is going to succeed.

Camps. There is no doubt that the C.C.C.Camps did a great deal to prevent crime in certain borderline cases. The experiment was rather expensive, but perhaps it was worth all it cost. After all, the prevention of delinquency challenges the entire community. Psychiatrists and educators may be leading the way, but success will come only when society at large enlists wholeheartedly in this important work.

Organized Play. I believe that the current movement for better-organized, well-regulated play — the effort to provide more public playgrounds, boys' clubs, Boy Scout and Girl Scout activities — will prove very valuable in preventing juvenile crime among certain types of high-strung, thoughtless, and feebly inhibited adolescents.

Family Recreation. The more recreation a family has, the more parents and children play together, the less there is of delinquency among its juvenile members. Recreation must not be confined to a two-weeks' annual vacation. It must be had every day and every week-end. In my opinion, family play

will do more to prevent youthful crime than all other influences put together.

Parental Attitude. One of the great handicaps in preventing serious juvenile delinquency is the attitude of many of the parents of wayward boys and girls. The records show that it is often the parent who has the child brought into the juvenile court. When the parent is merely anxious to be relieved of the inconvenience and bother of caring for, or disciplining, a child, it stands to reason that the home offers little or no promise of help.

Adolescent Vagrants. A serious problem that confronts the American people is what to do with boys who are beyond the reach of the compulsory education laws, and who refuse to work. Such youthful idlers are more or less out from under parental control, and they are not receiving the beneficial discipline that comes from regular employment, with the satisfaction of self-support. What shall we do with these idle youths? I believe the time has come to advocate the passage of *compulsory labor laws*. For the same reason that we have compulsory education, we should have compulsory work for boys after they leave school. In this way alone can youthful vagrancy be prevented.

Recreation. After providing opportunities for young people to work if they refuse to go to school, we should furnish an abundance of wholesome, intriguing, and, wherever possible, outdoor recreational facilities at the end of each day's labor and for week-end recreation.

Religious Instruction. In addition to providing young people with compulsory work and opportunities for wholesome play, parents or the churches or both should give them such religious instruction as will afford a spiritual view of the goal of human existence; when all this has been accomplished, I think we shall have done our best to save them from delinquency; and I believe that such preventive and curative measures will save more than 95 per cent of the normal-minded group. The feeble-minded are hopelessly unsuited to social

liberty. They should be adopted as permanent wards of the State and should be kept under lifelong supervision.

In dealing with serious delinquency, in those cases where the unethical and antisocial tendencies of young people have not been detected early enough or treated wisely enough to prevent these boys and girls from being arrested on criminal charges and brought into court, the following suggestions should be borne in mind:

1. *Segregation*. If such feebly inhibited and emotionally unstable youths are allowed to go on in the path of least resistance until they reach this sorry pass, we should see to it that throughout their incarceration they are kept away from older and more hardened criminals; in fact, they should be segregated from all prisoners who have been arrested more than once.

2. *Home Survey*. Sooner or later the State will make a thoroughgoing survey of the psychology of the home life and school experience of delinquent young men and women immediately following their first arrest.

3. *Prompt Trial*. The very next day after such an investigation is made, the trial should be held and sentence passed. There should be no delay in the trial, the sentencing, and the execution of the sentence.

4. *Psychologic Examination and Treatment*. More and more Juvenile Courts, especially in the larger cities, are being served by psychologic laboratories in charge of competent psychiatrists, and some day the courts of our land will treat these young offenders in the light of the findings of these laboratories. These laboratories should also provide treatment as well as diagnosis and should be directly associated with the courts, so that full co-operation can be had in carrying out the programs outlined by the psychiatrists in charge.

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INSTITUTIONAL CARE OF THE JUVENILE DELINQUENT

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Institutions may be privately, municipal, county or state administered, but their basic requirements are similar. Usually the ages are well defined within certain limits, but the sentences may be specific or indeterminate. The latter is usually preferable and discharge is preceded by a period of parole. Unlike institutions for older offenders, those for the youthful delinquent emphasize a scholastic atmosphere and should have the word "School" incorporated in the name. Nevertheless, a maximum of supervision with a minimum of repression is necessary.

Cases are referred by a juvenile court or welfare departments. All efforts should therefore be made to enhance the relations between the institution and the juvenile court or other referring agencies. Too often, institutional placement is used as a last resort, even after foster home care. By this time much effort has been wasted and the delinquent trend enhanced. If the referring agencies are well acquainted with the school program, better utilization of the facilities are obtained, and a better quality of material is available.

The obvious purpose is rehabilitation, and this includes protection and education as well as opportunity for developing emotional maturity. Often the individual is guilty of a minor offense or is a first offender. However, when the program is adequate, a judge may refer the individual for educational opportunities, or to protect him from a bad environmental situation. It is, therefore, important to prevent perpetuation of a delinquent trend, and to protect the impressionable youth from the chronic incorrigible and aggressive offenders.

Personnel is the backbone of the institutional program. It is impossible to establish a definite rule for a specific ratio

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per unit of population. Quality of personnel is obviously more important than quantity. Some form of training program should be organized to acquaint the personnel with the problems and goals of the institution. The use of uniforms is usually not practical: it is necessary to keep them immaculate and, on the other hand, it is much easier to wear a standardized civilian suit. This latter minimizes the atmosphere of regimentation. At least a brief period of training or formal instruction is in order before the attendant is put on his own. In some rural areas, husband and wife teams work out very well, especially where youngsters are involved. Men knowing trades work out well when they instruct in shops and in maintenance work. Some sort of merit system of grades and rank serves to spur initiative. Ex-service men are often well qualified and merit the respect of their charges. The personnel should realize that the personalities of their charges require remolding. This calls for a conscious effort to "put themselves over" by means of their own personalities and standards. It is their responsibility to create the human setting in which the institution is to operate and in which training is to take place. There is no telepathy more sure and rapid than the perception of attitude.

Mere incarceration is to be minimized, and educational opportunities, both academic and vocational, are necessary as well as recreational facilities. These are all preferably organized under one head. The academic program should be so developed as to compare with classes in approved schools, in order that full credit can be exchanged for work completed while in the institution.

The vocational program consists chiefly of shop work. When space is available, an agricultural program should be developed. Maintenance of an institution represents a large expenditure of money. When it is possible to develop agricultural facilities, a large sum can be saved by making the food supply as self-sufficient as possible in addition to serving as an excellent source of training when the inmates come from rural areas. The shop program is useful not only for vocational guidance but in maintenance work for the institution.

Institutional repairs are inevitable, and when the program is adequately organized all this work can be done with little outside assistance.

A well-stocked library including recent fiction, current periodicals, and technical books and journals, is a necessary unit. It is usually connected with the school and may be affiliated with local or state libraries.

It is well to have definite uniforms for both work and dress. This enables the fixing of emphasis on personal appearance behind the delinquent behavior. It is necessary to distinguish between the presenting symptoms as experienced by the individual, and the basic factors motivating these symptoms. A basic immaturity may be compensated for by aggressive behavior, while it also may be revealed as an inability to assume responsibility. Ability of the individual to correct these factors is a clue to his real insight and capacity for rehabilitation. Ability to change and correct those attitudes which are behind the problem involved is the ultimate goal of all psychotherapy.

The psychologist should be well trained and ranks in importance with other staff members. Testing is necessary to determine abilities, disabilities, and potentialities. The usual battery of tests include verbal, performance, and aptitude tests, and when possible more elaborate projection techniques, such as the personality inventories. Thematic Apperception and the Rorschach Test, for example, are of considerable assistance. All records should be protected not only from the inmates but also from inquisitive employees. Physical pathology can often be revealed in the psychological tests and it is important to have a complete battery of these tests. There are six types:

- (1) Intelligence tests, verbal and manual.
- (2) Tests of concept formation. These tests determine the basis of intellectual functioning.
- (3) Projective tests which give a skeleton outline of the personality and of the emotional patterns.
- (4) Content tests which reveal ideational content.

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- (5) Aptitude tests for the testing of special abilities.
- (6) Achievement tests for the testing of progress, particularly in learning.

(The latter two types are used chiefly with children and are less valuable clinically than the first four, which may be considered the routine tests.)

An X-ray is indispensable not only for diagnosing fractures but also for chest examinations for picking up lung pathology, usually tuberculous, and cardiac lesions. When possible, medical specialists such as cardiologists, ophthalmologists, otolaryngologists, and surgeons should be available for routine and emergency service.

The orientation program should begin the minute the individual enters the institution. With the exception of the more chronic offenders, the younger child is most vulnerable to all influences at this time, and for this reason should be handled with the utmost care. There is, first of all, the inevitable period of isolation and examination for health precautions. If possible, the head of the institution should personally meet the newcomer at the earliest opportunity. The orientation program, which begins on admission, serves another function. The individual is usually ill at ease, apprehensive, and often smarting under his sentence. He is at this time most vulnerable to personal influences, as he has not yet had much opportunity to mix with the other inmates who have already served time. An organized program affords this individual an opportunity for relief from his own problems.

By this time the boy has been studied by the medical services, the chaplain, and other interested members of the staff. He is then presented in person before a committee and offered an opportunity to express his preference for the programs available on the basis of his examinations. The boy is then assigned to a cottage and begins his program. This is not to uplift him in a moralistic sense, but serves to enable him to overcome his personal problems. He is also prepared to withstand the environment to which he will eventually return. A

definite daily schedule is necessary for proper functioning of the integrated program and to teach the individual to function with consideration for others.

Segregation is necessary and must be given considerable attention. It is not too easy to separate the first offender and the chronic offender. Nevertheless, an impressionable first offender must be protected from the chronic offenders and "wolves". The effeminate and emotionally immature youngster must be carefully scrutinized for homosexual tendencies. In some institutions race segregation is also necessary. The Negro is more prone to show homosexual tendencies during incarceration and to revert to heterosexual practices when released. This is not as frequent among the white race. In females there is a tendency for one of the lesbian type to acquire a coterie of subjects. These are individually provoked to some form of demonstrative insubordination as an expression of their devotion. Both sexes are guilty of such offenses and can only be controlled by careful supervision. Masturbation should not be permitted to be too overt but it should not usually be considered a punishable offense when surreptitious.

It is important to appreciate that the individual's chronological age is not always commensurate with the physical development or emotional maturity. Frequently, overdeveloped youngsters appear out of place with those of their own age. Nevertheless, they cannot be trusted with those too much older.

During the orientation program the individual should become acquainted with all the rules and regulations of the institution. This is preferably organized and available for distribution in printed form. When the newcomers can be organized in a group for orientation, it is well to present the heads of the various departments in a lecture program. Here they can outline their individual functions and become personally acquainted with their future charges.

Adequate discipline is the backbone of all penal institutions. Too often this is highly repressive in nature, but proper development of the youth demands opportunities for personal expression. Homosexuality, gambling and running away are

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the three inevitable and common offenses, to be kept at a minimum but never to be completely controlled. The usual procedure is to outline rules and regulations with specific penalties for all infractions. This is practical for older offenders, but youth demands a much more flexible program. A discipline or adjustment committee serves this need. It should consist of representatives from the medical, scholastic, and administrative departments. The offender is brought before this group and has the opportunity to defend himself from the charges against him. Corporal punishment is never indicated, but this is often meted out by associates on whom the punishment may reflect. Formal punishment should consist of loss of privileges, loss of good time, extension of sentence, and, as rarely as possible, the use of solitary confinement. Despite all precautions, efforts to make some form of alcoholic beverage will constantly arise. This should never create an issue but should be dealt with in the matter-of-fact manner of any breachance. Most schools also have a military program in the form of drills, a band, and if possible even an orchestra. Uniforms are used, for dress and drill, and are the standard form of clothing for daily routine.

Four basic needs of security, responsibility, social, and emotional expression must be met. These have not been adequately met or the individual would not have been involved in the difficulty that led to his commitment.

A basic insecurity is frequently the major factor predisposing to most forms of delinquency. An environment that serves this need for security is necessary and possible in an institutional program, and must be such as to meet all physical and mental needs.

The individual's inability to assume responsibility is also usually behind the delinquent behavior. This should have been inculcated in the more impressionable early years and is necessary before the individual can acquire emotional maturity. Every possible opportunity should be available in some form of merit program to meet this need.

Social expression, or the ability to adjust and fit in along

with others, is necessary for adequate adjustment in civil life. This is difficult to provide for but remains an essential component in the institution's attempt to fit the individual for better adjustment on the outside.

Emotional expression involves learning the satisfaction of successful accomplishment. Some form of individual and creative expression must be discovered and developed to bolster individual self-esteem. This encourages successful competition with others and minimizes the possibility of developing the so-called "inferiority complex". This portion of the program devolves, to a large degree, on the academic or vocational program.

The medical organization is one of the most important parts of the institution program. For this reason it always deserves top rating in all appropriations in the budget. Both personnel and physical equipment should be the best obtainable and well within minimal requirements for best health standards. The staff depends on the size of the institution and its location. When located in a rural area, and away from other medical consultations, the staff should consist of a medical man, a psychiatrist, and a psychologist. The latter is also associated with the academic program, if not on the academic staff. The medical man may function alone if he has had adequate psychiatric training, or if a psychiatric consultant is available to participate regularly in the program or on a part time basis.

Each inmate, boy or girl, should receive an examination on admission. This is followed by a period of isolation which is necessary, first of all, to avoid introduction of an infectious or communicable disease. The second reason is for the purpose of orientation to permit the newcomer to get his bearings, as will be shown later.

Examination should include a careful physical survey to ascertain the presence of any chronic condition. Special care should be taken to determine if there is a need of glasses to correct an error of refraction. It is amazing how often this condition is discovered when not suspected. Equally important

is to discover any defects of hearing. A loss of hearing of over twenty-five percent is of serious consequence. Routine blood counts often reveal significant anemias or the presence of a chronic infection. Serological examination of the blood is obviously always indicated. Smears are collected from all females as well as suspicious discharges from the males. Stool analysis are too often neglected. They are especially important in the southern states, but many delinquents eventually travel through this section of the country and therefore hookworm disease may have been contracted. A significant number also show the common infestations that can only be discovered in stool examinations. All institutions, no matter how small, have to include a dispensary and hospital, as well as isolation beds. Although immunization for diphtheria, small pox, and tetanus are necessary, other common infectious diseases will always crop up and require immediate isolation. When possible, a registered nurse should be a regular employee. In smaller institutions boys can be trained for this work and can be very efficient. First aid instruction, usually in a class, is always a necessary part of the program. It is most successful on a volunteer basis and well organized instructional data is available from the Red Cross. Candidates for nursing are frequently discovered in this group.

Daily sick call is too often an annoyance but a necessary evil. "Goldbricking" can never be completely avoided. A sick line can be collected and brought to the dispensary. Perhaps a less satisfactory arrangement is to visit the individual cottages or dormitories at least daily in order to prescribe the usual laxatives, to render first aid, and to pick up more serious infections.

The psychiatric and psychological programs are inseparable and mutually dependent. Although psychoses are not common, they do occur with alarming frequency, and incipient psychoses can often be discovered. The too-common diagnosis of psychopath should be avoided. Emotional immaturity and neurotic manifestations are quite common and require psychiatric therapy. Group psychotherapy is a most important

part of the school program and, if properly developed, can expedite the entire process of rehabilitation. Psychotherapy involves more than the therapeutic relations between the individual and worker. However, in addition to the effects of a wholesome environment, an opportunity for enabling the boy to develop personal insight is necessary. In a certain percentage, the environment is primarily the factor behind the delinquency. However, in most cases, the importance of the personal factor is obvious. A combination of formal lectures, including questions and answers, serves as a prelude to individual therapy. This should include elementary psychology and physiology, presented in a manner within the grasp of the average boy. Especially important is the subject of sex and personal hygiene. Masturbation is not harmful in itself, but most people are misinformed about the consequences of the act, and this is a frequent source of anxiety. Venereal diseases should be discussed in a matter-of-fact manner, with illustrations and with a minimum of moralizing. Individual therapy is then in order, but time usually limits this. It is possible to achieve excellent results while interviewing only two boys at a time with similar or even contrasting problems. The individual first learns his problems are not unique to him but exist in others. This marks the development of initial insight. The next step is to enable the clarification of the specific problem of discipline.

It is obviously difficult to permit money to circulate. Some medium of exchange is necessary, and candy or cigarettes often serve this purpose surreptitiously. The former should be dispensed to the younger group and the latter to older boys. Pipe smoking should also be permitted. It is usually well to secure permission from the parents for the boy to begin smoking.

The most important single factor is the maintenance of good morale. Consistent justice and adequate recreation are necessary for good morale. Group pressure is more heavily felt in a confined group. The "Borstal System" of England

reflects this approach and their excellent results speak for themselves.

Organized recreation means more than athletics, although this theme must be emphasized. However, to reach all whose athletic prowess is lacking, other forms of recreation are needed. Indoor games are necessary, and this inevitably brings up an opportunity for gambling. It is practically impossible to stamp this out, although it must obviously be discouraged. Hobbies of all forms are to be encouraged. Playing cards should be available at all times for games such as cribbage and rummy, which are excellent for only two players. Magic, or legerdemain, is always popular, and this can be developed with cards alone. Athletics should include both intramural and dextramural activities. Team spirit is most important and, if properly developed, carries over into all activities and may continue to the individual's advantage when he leaves the institution. This can be further developed through extramural activities, especially athletics. The participants will soon appreciate that the school's reputation is based on the nature of their showing. Scholastic standards should be maintained to permit such representation and also, obviously, a good disciplinary record. Adequately organized recreation is as important as any single factor in fitting the individual for participation in civil life.

Spiritual guidance is not to be subordinated to any other activity. Racial tolerance must be developed from this approach and perpetuated in all other forms of group activities. Many theological seminaries permit their students to serve an internship or spend their summers at those institutions where they can be properly supervised. These students invariably reflect their enthusiasm and earn the respect of their spiritual charges. Whenever possible, a chaplain in residence serves a most vital need, and he usually co-operates well in all activities other than those directly connected with his religious function. Religious attendance should never be compulsory. A well-organized program never needs this element to secure a good attendance. Proselytism should be discouraged. Often a discouraged

youth envies the satisfaction an associate secures from spiritual expression and seeks a similar outlet. Parents intensely resent proselytism and their written consent should be secured before this is permitted. The parents also appreciate assurance that the opportunity for religious expression is available. Whenever possible all other activities should be subordinated to religious services on holidays. The chaplain should always have access to any of the inmates at any time, and especially to those in solitary confinement. He should be a member of most official committees, including those dealing with classification and discipline.

Most important is a central record system to which all departments send individual reports copied from their work. This includes all work done and is a running record of all progress. However, included in the individual record are available social data and finger prints. No inmate should at any time have access to a complete report, although he may help on the report from a single department. Even only a few of the personnel staff should see these records, which should never leave the office except for unusual occasions.

In anticipation of discharge or parole, the candidates should enter some form of release program. This is necessary to fit the boy for return to civil life, and while privileges are increased, responsibilities are also increased. The home or work placement is investigated before release. Proper clothes, which are not too conspicuous, together with some gratuity, are given to the boy on his discharge. He should be encouraged to maintain contact with the friends he is leaving, including both inmates and personnel. By this time he should have a sense of responsibility and the realization that he is to serve as an example of the school's efforts. It is to be desired that he should not be ashamed of his school record, but realize that his future conduct will, to a degree, determine the reputation which he should uphold.

PROBLEMS IN THE TREATMENT OF JUVENILE DELINQUENCY

WILLIAM LEAVITT, M.D.

When Samuel Butler related in *Erewhon* that the inhabitants of that country placed their delinquents in hospitals and punished their sick, he, in the first instance, wrote more wisely than he satirically intended. It has become a truism to say that punitive and retributive methods of dealing with delinquency have not prevented further delinquency. Such methods relieved society of the discomfort of having the delinquent in its midst. A criminal was considered a peculiar species, a type. Lombroso and others saw in the criminal a primitive, atavistic type, anomalous in modern life, with physical and mental stigmata, who required segregation. More careful observation and understanding led to the realization that such generalizations are inadequate. We are aware that constitutional factors and organic disease play a part in some individuals, but we no longer see in delinquency a stigmatic organic type.

Other causes of delinquency were advanced and emphasis placed upon heredity, intellectual retardation, poor socioeconomic environment, and changing standards in immigrants, among others. Each cause gained its appeal by its relative simplicity. A simple prescription to cure an ill is appealing, but a simple panacea such as the establishment of a boys' club in a neighborhood (which often does not reach the delinquent) will not of itself cure the individual and the social ills which produce delinquency.

Those who have spent most time in the study of delinquency have been least satisfied with simple solutions of the problems involved. The more painstaking the research the less satisfaction was found with any one cause or causes. Formal static viewpoints were rejected and the conviction grew that each delinquent was a person unto himself, that it was not the

so-called cause which was of primary importance but the individual who reacts to a situation and who must be studied as a personality. A series of causes operative in one individual in the production of delinquency may in another, even in a closely related member, produce a frank neurosis, or may have no ill effect, by reason of a personality development which renders him immune to such factors. The keynote was struck by Dr. William Healy, who recognized the importance of the individual personality in reaction to unfavorable elements in the environment. The individual and the environment constitute a total situation which must be approached as an individual problem.

The approach to the realization of the importance of the individual personality with its emotional and character structure was aided by the understanding of the structure of the personality by such investigators as Freud, Meyer, Alfred Adler and others. If one were to erase the awareness of the processes of character and personality development learned from these teachers, one might easily return to primitive methods of appraisal and treatment of delinquency. We now consider delinquents as emotionally frustrated and thwarted individuals who express themselves in the distorted behavior of delinquency. This distortion is from the point of view of the normal individual. Like the delusional utterances and acts of the psychotic, to whom his delusions are reasonable and satisfying explanations of the problems which present themselves to him, so the delinquent's behavior satisfies and allays his inner drives and desires. It is the most satisfactory solution of his emotional and volitional life. He may agree, from an intellectual point of view, that such behavior is wrong, but a disturbed emotional life motivates his conduct and finds such behavior satisfactory. I call to mind a boy who stole in the home of an adoptive parent, who had adopted the boy in a burst of sentimentality and who soon rued her act of adoption and showed her rejection of the boy. This boy ceased to steal in another home where he met with emotional warmth.

We describe the speech of the psychotic as incoherent

and the behavior of the delinquent as distorted because we have not sufficient knowledge of what is at the root of the psychotic's speech and the delinquent's behavior. We have further masked our ignorance by citing symptoms and calling them disease entities. In the older psychiatry, kleptomania was a disease unto itself and lists of compulsive acts and phobias were given. Similarly, in child psychiatry chapters are devoted to enuresis, habit spasms, and the like. To consider delinquency merely under headings of stealing, sexual immorality, truancy, and home desertion, is to disregard the dynamics of the emotional situations which brought about the acts.

What is the language of the delinquent? It is a language of insecurity, frustration, fear, anxiety, guilt, antagonism, aggressiveness, and passivity. This language attempts to say that the child, suffering from frustration in his personal relationship to the social structure and more particularly to those about him towards whom he is most responsive emotionally, and ineffectual in his attainments of the satisfactions which are obtained by the normal efficient personality, resorts to compensatory gratification.

This basic insufficiency which prevents attainment of normal satisfactions and self-expression is complex in its origin. First, there are constitutional factors. Some children from babyhood on stand out as disturbed and emotionally maladjusted. They often manifest explosive outbursts of maladjusted behavior, much as an epileptic child stands out from his normal siblings. One is impressed that the behavior is associated with organicity. Recent electroencephalographic studies lend strength to such an impression. Again there are children who have suffered a recognized or easily passed over encephalitis, such as a mumps encephalitis, in early childhood and when behavior disturbances also occur the organic implications are obvious. Such organic defects, alone or in reaction to adverse family or socio-economic conditions, produce chronic abnormal reactions, impulsiveness, and aggressiveness without adequate inhibitions. We have here definite psychic disturbances asso-

ciated with physical disturbances. Such physico-psychopathic personalities are practically irreversible, in whom attempts at reconditioning will accomplish little or perhaps nothing. These individuals, for their own sake as well as that of society, should be placed in a controlled environment for a prolonged period, where medical, psychiatric, and educative treatment, in the spirit of a hospital treating the sick, may in time produce some rehabilitation and the child gradually may be reintroduced into a free environment.

Each year as the writer looks over the statistics for that year he is impressed by the fact that the number of such individuals is small. In the great majority of delinquents the constitutional elements are much less in evidence. It is true that the histories of many delinquent children show that from early years on they are not as easily managed as their non-delinquent siblings, are restless and hyperkinetic, as though constantly seeking stimuli and satisfactions. But the question arises whether symptoms suggesting a constitutional organic state may not have arisen as a result of mental experiences.

Many of the milder of these delinquents show behavior which represents a temporary reactive state to disturbances within the family, school, or social group. If the behavior is the outgrowth of disturbed relationships between the parents themselves or the parents and the child, the child can be helped if the parents can be brought to understand the motivations of the child's behaviour. Proper grading in school, facilities for self-expression, recreation, positions of minor responsibility, attention to physical defects about which a child may feel inferior; any or several of these may help. Such children are often screened before reaching the Children's Court by case work agencies, or by such an agency as the Bureau of Adjustment in the Domestic Relations Court of the City of New York.

This brings us to that group which forms the majority of the delinquent children who come to court. Many of these children show intellectual retardation, malnutrition, physical defects and endocrine disturbances, or come from dirty or

poverty-stricken homes, or homes in high delinquency areas. Any of these and other inadequacies are features which become effective in producing delinquency when there is added also the common factor found in these children, namely insecurity, uncertainty, and dissatisfaction as a result of a poorly knit emotional life. Many of these children fear that they are not getting their share out of life; they have a feeling of being thwarted, and behavior which constitutes compensatory gratification follows.

To a child, the relationships of the various members of the family, more particularly that between the parents and the child, constitute values which far outweigh any other emotional values in his environment. Parental patterns and parental love or rejection, ego ideals and character formation, go hand in hand. A child who has been trained by a loving mother to control his bodily functions may again wet the bed if the mother goes to a hospital and the care of the child devolves upon an indifferent relative or stranger. On the other hand, persistent bed wetting may be an expression of a reaction to a rejecting parent. Because emotional attachments outweigh other considerations, a child placed away from home in a far better physical and moral environment will cry to go back to a home where he has been neglected and hurt. Since character formation depends upon emotional attachments, poor parental spirit, constant bickering between parents, questionable behavior by parents, flagrant drunkenness or immorality on the one hand and unreasonable attitudes towards the child and overprotection or rejection on the other, will produce greater insecurity than actual deprivation of adequate food and shelter.

A girl of fifteen who as a young child had been placed by her unmarried mother in the care of another woman was brought to court. The visits by the mother, a comparatively young, attractive but unstable woman, lightened the child's life so that some definite attachment grew up between them. When the child reached adolescence, the mother, responding to the child's attractiveness and grace, took her with her to

live in her apartment. The mother led a highly emotional life at a physical level, and the child was a witness to her affairs with various men. The child had never shown delinquent trends in her former home. Quarrels soon developed between mother and daughter, the mother objected to the child's self-assertion and demands for freedom of movement. The child deserted her home time after time and stole from stores. She did not have any sexual experiences. She was returned to her previous home but her thefts continued and she was brought to court.

We actually find in the history of delinquents a high percentage of parental difficulties, divorce, separation, broken homes, dependency, neuroticism, and psychoses. Many of the parents' difficulties are due not alone to their own emotional problems but to poor economic conditions, the problems of a large family, a lack of facilities for advice and education, or failure to avail themselves of existing social services. The writer has seen successive children in a family brought to court follow the same pattern of delinquency. The same paternal inadequacies brought about emotional frustrations in child after child and these, combined with adverse environmental factors, induced delinquency.

Prevention of delinquency is a community problem and begins in the home. It is in the home where character is formed and habits set. Warmly human, decent parents with low income build more strongly than wealthy parents who depend upon buying values for their children. Environmental situations outside the home are of great importance, but a well built character does not react to unfavorable elements in the environment by delinquency. A painstaking history will usually give information that emotional disturbances manifest themselves early in the life of a delinquent, and it is not surprising to find that the overt act which brings a child to court was antedated by delinquent behavior for some time. Eleanor and Sheldon Glueck found the average age of the first delinquency in *One Thousand Juvenile Delinquents* to be nine years, and that delinquent behavior antedated the first court appearance

on the average by five years. It is because delinquency begins in early and impressionable years and continues for so long a time before active measures are employed to combat it, that treatment has in so many instances been ineffective. The early recognition of predelinquency and delinquency is of the utmost importance.

The problem of the community is the education of its various family groups to an awareness of the responsibilities of the parents towards their children, an awareness so far as possible of their own motivations and behavior, how these affect their children, and a recognition of what constitutes predelinquent or neurotic manifestations of frustration.

One of the earliest signs of predelinquency is beginning truancy. The inability to maintain a comfortable and satisfying social level with fellows under conditions of sustained application expresses itself in truancy, often in the company of other children but also alone. The child will wander in parks, go to the movies, or stay at home if the mother is at work. I have seen truancy with the mother at work cease when the mother stays home. In a few instances truancy may be initiated or encouraged by a mother keeping her daughter out of school to look after the younger children or to help with the housework.

When a parent or parents attend a parent-teacher's meeting in school, the child of necessity feels a greater integration of the home and the school. Schools, in many instances, can be used as centers for community education and planning. The difficulty has been that those parents who most need to attend parent-teacher meetings and school centers do not attend.

Certain behavior should warn a parent or teacher of the possible onset of delinquency: boredom, moodiness, marked inattention, overactivity, (the presence of many scars, especially head scars, in delinquent children brought to court is often an index of the degree of overactivity), excitability, flagrant lying, and failures in school work not commensurate with the child's actual intellectual attainments. Next to a parent, a teacher has the opportunity and the responsibility of recognizing such

children. It would be well for teachers to receive special instruction in matters of mental hygiene for additional understanding of the problems involved.

Such children should be brought to psychiatric and child guidance clinics. Where such clinics do not exist, they should be established by the State. An isolated child guidance clinic may do some good, but the problem is so entwined with other community problems that a total community program is necessary. Clinical medical treatment, economic rehabilitation, and other social services rarely alone remedy the situation. The local community should unite all its agencies into a central coordinated agency and program, each unit knowing that it can best serve by taking into account all the other agencies. Overlapping would be avoided. Even as a child's ego is stimulated by being given a position of minor responsibility, so children can be stimulated to help adjust their problems through youth organizations which could contribute constructively towards a community program. The standards of an effective young group can communicate itself to less effective children if the latter are approached not in a holier-than-thou manner, and if underprivileged children are not overwhelmed by a too ambitious program. Children can be brought to regard socially unacceptable behavior as unsportsmanlike, and delinquency can be made unpopular. The opportunity is here taken to reiterate that such remedial measures are effective only if the individual needs of the child also receive attention, since some children's delinquencies are motivated by unconscious guilt feelings, and socially unacceptable behavior may be entered into to satisfy feelings of inferiority and a desire for punishment.

Since delinquency is a wide problem and localities may be financially or otherwise incapable of carrying on a program for themselves and in relation to other communities, state help is necessary in many instances. In New York a Youth Correction Authority has been considered. It is to consist of specialists in diagnosis and treatment to whom courts for youthful offenders would commit their charges for treatment purposes.

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This Authority would utilize private and public social agencies,, medical, psychiatric and psychological services, schools, recreational centers, correctional institutions, and parole officers. In the field of prevention of delinquency, there has been created in New York State, the New York State Youth Commission, to provide for the setting up of youth bureaus by counties and cities, and to make state aid available to municipalities for approved projects.

Parents can, in most instances, be brought to cooperate in the discussion and understanding of their children's difficulties. Some cases are referred to the Bureau of Adjustment of the Children's Court. The parents and child recognize in this a quasi-authority; full authority can be provided by the Children's Court if allegations of neglect by the parents or delinquencies by the children can be sustained. Often the cooperation of parents can be obtained by intervention of the family pastor in whom faith is placed, whereas social agencies may be looked upon by the parents and child as formal, critical agents.

The purpose of the Children's Court is the guardianship by the Court of neglected and delinquent children. It is a socializing institution which uses the law as a dynamic and provident agent. Having obtained jurisdiction over a child and rendered an adjudication, it utilizes the help rendered by sociologic, educational, psychological, medical, and psychiatric agencies in understanding the causes of a child's neglect or delinquency, in safe-guarding the welfare of the child, and in helping him to normal living.

The problems of the Children's Court are many. Not the least are the lack of facilities. Results can usually be measured by the degree of effort employed. In state hospitals for the mentally ill the number of acutely disturbed patients who are placed in physical or chemical restraint is in inverse proportion to the number of nurses and physicians in the ward. Nursing and state hospitals, attendants and insane asylums are complementary. The more nurses, the less restraint is found necessary, and the less exhaustion develops. This is a brief for intensive work by psychiatrists, nurses, probation and

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parole officers, and psychiatric social workers with those who suffer from disturbed human behavior, be it psychotic, psychoneurotic or delinquent. When poorly prepared probation officers are loaded with a vast number of probationers, meagre results can be expected. Treatment is further hampered by the lack of facilities for foster home placement, and by too few adequate types of institutions. Many neglected and delinquent children must be returned to their homes even when it is known that the parents are unfit to deal with the child's problems. Yet the cost of one murder trial will pay the salary of a number of probation officers or provide good type of foster homes for many children.

When a child is brought to Court an initial hearing is held. In the City of New York a large proportion of the children are paroled to their relatives. Unless the type of delinquency does not warrant it, or there is something flagrantly wrong with the family situation, this is the course usually followed. Other children are sent to homes of detention such as the Childrens Centre, Queens Society for the Prevention of Cruelty to Children, or to the Youth House which is prepared to take on the child as a social problem for a limited period of observation and study. In Boston, children are placed temporarily, not in institutions, but with families provided by the Children's Aid Society.

An investigation by a probation officer assigned to the case then follows. This includes an investigation of the home, its economic condition, interviews with the child, the parents, siblings, and other relatives; school record and attainments; church affiliation and attendance; character of and facilities for recreation; Boy Scout or other group activities such as Boys' clubs; work record, if any; interviews with the family physician and family pastor. The case is cleared through a Social Service Exchange to learn what social agencies have had contact with the child or the members of his family, and what light these can cast upon the problem. At the initiative of the judge or at the suggestion of a probation officer, representative of a school or a social agency, a psychiatric examination

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is ordered. Owing to limited psychiatric facilities only the more severely disturbed children receive this service.

A psychiatric clinic connected with a Juvenile Court has certain advantages and disadvantages. A disadvantage is that a child is inclined to identify the clinic with what he regards as a correctional and punitive authority. It would be well in arranging for a psychiatric examination to avoid reference to the word psychiatric and to use the word medical or clinical, because a child and often the parents as well come to the clinic convinced that the examination is for the purpose of ascertaining the child's sanity. An advantage in a Court clinic is the authority which can be used to bring the child to the clinic and to assure follow-up treatment.

A Psychiatric or Child Guidance Clinic should have an adequate staff of psychiatrists, psychologists, and psychiatric social workers. Prior to the examination the psychiatrist should have at hand a report by a psychiatric social worker (in the Domestic Relations Court of the City of New York the report is prepared by the probation officer), of the child, his home, family, school, economic, and other social conditions. The parents are interviewed by the psychiatrist and a history is obtained as to the child's physical, emotional, educational, intellectual, and social equipment. In the process of taking a painstaking history from the parents, one obtains some leads as to the personality of the parents and some of their problems. A psychological, medical, and psychiatric examination of the child then follows. In many cases it is found that the child's difficulties are related to the home situation and the parents' own problems, whether these arise from personality conflicts, and their expression in alcoholism, constant quarrels or separations, or whether they arise from poor economic conditions. The child must be treated as part of the family group to which ultimately he must return and adjust himself. To treat a delinquent child without treating the home situation is like treating a malarial patient without regard to drainage and mosquito control of the area to which the patient must return. In most instances, the child is tied to the family inadequacies and will

change only if the parents can be brought to understand the part they play in their child's emotional life.

In many cases, not the type of delinquency but the understanding and help which can be obtained from the parents should be the main factor in determining whether or not a child should be allowed to go home or be placed in a foster home or correctional school. If there are no contraindications, it is best that a child receive help and treatment in his own home. Sooner or later he will return, and he must learn to adjust himself there. Then again the child and his parents are spared the pangs of separation. When, however, parents are found to be living distorted and disturbed lives, and can see no further than their own neuroticism or maladjustment, placement of the child becomes necessary.

In some instances a child may be dismissed by the court, with the understanding that he will be supervised by a social case-working agency. This may be done when the delinquency represents an isolated act, and when the parents are interested and receptive to advice. When more sustained supervision backed by authority is necessary, the child may be placed on probation. Apart from the probation officer's visits the child should be followed in the psychiatric clinic. Medical recommendations should be carried out with regard to nutrition, teeth, tonsils, circumcision, plastic surgery, attendance at a cardiac clinic, and the like. Any data which may help the child in school should be reported to the school, such as proper grading, the child's emotional needs, and outlets in physical activity and sports. The child can be referred to recreational centers, Boy Scout groups, boys' clubs, and for summer camp placement. There is a scarcity of Big Brothers at the present time: they have a definite function.

The psychiatrist tries to obtain the confidence of the child and his parents. If confidence and transference is to be obtained, they must feel that the psychiatrist has an understanding of their views, that he shares some of their points of view, and that he does not set himself up as a formal and superior authority with ideas alien to their own and with feelings out-

side of their experience. The personal element here is more important in healing than in an acute infection. Confidence makes a patient more comfortable, but penicillin is effective whoever prescribes it. Emotional frustrations unfortunately cannot be resolved by such methods. The psychiatrist must be understanding, interested, kind, and tactful. He must be friend, father confessor, and adviser. The parents must be helped to resolve their conflicts, and the energy involved in creating the child's delinquency must be directed into socially acceptable lines of behavior. Since many of these children are hyperkinetic, outlets must be found for their energy, until such time as allayment of inner desires may effect a lessening of overactivity. The amount of time spent with parents and the child is not always an index of the prognosis. Those cases which need many interviews and long periods of treatment are usually the severer disturbances which may show little improvement. In many instances, four or five interviews can do much to help adjust situations.

When owing to inadequacy in the parents, a child cannot return home, foster home placement is advised unless the child is so disturbed that he or she will not fit into a foster home and will either go back to his own home or run away elsewhere. The type of foster parents is of great importance. Whereas in most cases children in foster homes look forward to the time when they will rejoin their parents, brothers, and sisters, it sometimes happens that they meet with such calmness, warmth, and understanding in the foster home that they are loath to leave it. Many a parent fears that he or she may be supplanted in the child's affections, and careful and tactful handling is necessary. The visitation by the parents is a delicate matter, since visits may seriously disturb a child who is beginning to adjust, and may undo any good already accomplished. The children placed in foster homes should be visited by the psychiatric worker and referred to the psychiatrist as need arises.

When a child does not do well on probation in his own home or in a foster home, placement in a correctional school

becomes necessary. It is not possible within the confines of a chapter to take up the subject of correctional schools and institutions for delinquents, but a few principles may be mentioned. Every child must be studied and treated as a total personality and an individual problem. In order that the child's problems be understood and the child helped, it is apparent that the personnel of any correctional school is of greater importance than any physical advantage in housing or recreational facilities. Resentment over placement must be overcome, and a child must be made to feel that he takes his place in the school with no tags attached to him. The particular programs in the school, whether academic, vocational, or recreational, must be entered into with an understanding of how they fit in with the child's inner life and particular drives. Advantage should be taken of special skills which either have been unrecognized or have had little attention paid to them. Opportunities should be provided for overactivity to take the path of sports and useful work, and opportunities given for constructive self-expression in individual and collective action. The child should be encouraged to exert choice in vocational and other activities, since he must ultimately take his place in the community, away from the more or less fixed program and protection of the correctional school or institution and the controlled life of a small compact group. The boy should learn that he leaves the school not because he has served a sentence but because he is well adjusted and trustworthy. Such a viewpoint predicates that a child should not be sent to a correctional school for a fixed period but until a reasonable degree of adjustment takes place.

The parents, the home, and the coordinated agencies in the community should be prepared for his coming. Removal of the home from an unfavorable environment should be effected if possible. If the home remains broken and unsatisfactory, and if the parents cannot effect a proper adjustment of their own difficulties, it may be necessary to place the child for a time in a foster home. Until such time as the boy proves otherwise, the community must accept him at his new values.

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If the community can be brought to understand the meaning of juvenile delinquency, then the child will no more be excluded from its program than will a child who at one time had active tuberculosis and is thought fit to go home from the hospital. If, as often happens, the child comes from a home of a low socio-economic level, then the level of this home should be raised, as it should be raised for a child with arrested tuberculosis who should not be allowed to return to a sunless home and crowded living conditions. The child should be kept under tactful supervision in the community by a supervising agency.

There is need of hospital care and of a hospital school for some very seriously disturbed children who require intensive psychiatric care. In New York City such children are often referred to a special children's ward in the psychiatric department of Bellevue Hospital. Some children are sent to the children's division of the Rockland State Hospital. Only a few children receive this care because of lack of facilities. Many more would be referred to these agencies if facilities were available.

The problems of juvenile delinquency must obtain further enlightenment from scientific research along social, economic, educational, and psychiatric lines. In the light of our present knowledge, progress in the treatment of delinquency lies not only in improving material comforts and better living conditions but in an awareness, by those who stand in emotional relationship to children, of their own inner motivations, particularly as they affect the children. This awareness will help them to understand what disturbs their children. Such enlightenment must reach all members of the community. The community itself must develop a social awareness and an understanding of its motivations. Juvenile delinquency is the problem of the individual, the home, and the community.

THE CLINICAL RECOGNITION OF MENTAL DEFICIENCY

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We cannot divorce the physical and intellectual development of an individual from his relationship to the world about him and the role he plays in that world. In other words, individuals must be considered from the viewpoint of biological concept.

For the present discussion let us accept the definition of mental deficiency given by Tredgold, "—a state of incomplete mental development of such a kind and degree that the individual is incapable of adapting himself to the normal environment of his fellows in such a way as to maintain existence independently of supervision, control, or external support."

We must bear in mind that we are not speaking of an object but of a human being who differs from us, not in kind, but only in quantity and quality of reaction. Let us not forget that the mental defective does not always look the part to the casual observer. He is not always a "Mortimer Snerd". Let us remember that the mental defective may vary widely in intelligence from the lowly profound idiot, absolutely unaware of his environment, up to the level of dull normal intelligence. Too often emphasis is placed upon the idiot and imbecile levels only, and too often we minimize the defectiveness of the moron and the borderline intellect.

This paper is not intended to be an exhaustive encyclopedia of mental deficiency, and for that reason etiology and types have been assiduously avoided in an attempt to guard against creating a descriptive outline of physical types. Our aim is to develop a word picture of the general mental defective, to portray his normal inclinations, and to point out his limitations. I have felt that within the scope of the present paper etiology and types have no place; for, regardless of what

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produced the defect, or to what degree the defect, the fact remains that they are defective, and being defective they are incompetent of adapting to the existing social structure.

The discussion might be handled in a number of ways. It might be approached in a descriptive manner, setting forth various types and going into detail about Mongoloid, Cretin, and other physical variations. Or again, it might be treated with emphasis placed upon the various levels of deficiency, outlining the idiot, imbecile, and the various levels of the moron. Both such approaches would require much more space than has been allotted. I have, therefore, attempted only to show a working picture of the mental defective as seen, the fields of inquiry to be considered in making the diagnosis, and a brief summary of the diagnostic aids at our disposal.

In making our study we are forced to rely upon three things; first, the history we are able to obtain; second, objective examination of the patient; and, third, results of such tests as may be available to us. Too often we find ourselves handicapped by inadequacy of one or all of the points enumerated. The history given may be incomplete, vague, sketchy, or deliberately distorted. Statements of the patient himself are invariably unreliable. Statements given by immediate members of the family are often deliberately falsified either in a spirit of wishful thinking, in an attempt to apologize and place the blame for the patient's condition on some person or circumstance, or by attempting to remove the fact of the patient's defect by blandly ignoring it. The family is seldom able totally to face the reality of the situation. The histories obtained from court records and social agencies are often incomplete but generally fairly reliable. Occasionally, information is withheld if it appears that it will detract from the objectives in mind, namely, getting the individual into an institution.

Objective examination of the patient gives considerable data. During the examination the individual should be given freedom to express himself. An attempt should be made to establish a friendly relationship and to eliminate any fears. The way the patient walks, his mannerisms, the things which

arouse his curiosity, his conversation, and his questions all may give the alert, informed observer information needed in understanding the patient's limitations and abilities. Where it is possible, it is frequently worthwhile to observe the individual undressing for the examination and dressing again, as clues relative to his mentality often are given as he attempts to put on his shoes, tie his shoes, and button his clothing. The matter of psychometric testing is carried elsewhere in this paper. Again, however, satisfactory relationship is essential for the proper evaluation of tests. Where time is not a factor, it is often wise to postpone psychometric testing until the individual has had an opportunity to acclimate himself to his surroundings. If institutionalized, this may mean a matter of several weeks, but the delay seems justified by the more accurate results obtained.

The diagnosis of mental deficiency should not be made on the basis of any one factor but should be made only upon sufficient supporting data from an adequate number of fields of inquiry. It has been the custom of the Polk State School to consider the newly-admitted patient from the standpoint of the following fields of inquiry:

1. Physical Examination
2. Family History
3. Personal and Developmental History
4. History of School Progress
5. Examination in School Work
6. Practical Knowledge
7. Economic Efficiency
8. Social History and Reactions
9. Moral Reactions
10. Psychological Tests

Physical Examination: The mentally deficient individual, in general, is undersize in height and weight as compared with the normal person. Physical deviation is most marked in the lower degrees of deficiency and less so as the individual approaches the borderline limits of normalcy. The so-called stig-

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mata of degeneration are probably unreliable. General reactions may be that of apathy or hyperactivity. The patient may be inquisitive, talkative, or sullen. His general expression is not alert. Nutrition may be good or bad depending upon home conditions and personal habits. Cleanliness is more a mark of environment and degree of supervision than a matter of personal desire. Dress is usually either slovenly or gaudy with exaggeration of personal adornment. Males usually run to an excess of campaign buttons, tie pins, and the like; females would attempt a heavy and ill-chosen use of cosmetics. In walking, his gait is often shuffling and dragging in character. He does not have the quick and easy step of an alert individual. Coordination is usually poor, and poorest in the most defective. Coordination tends to be most deficient in the smaller muscle groups. Defects of sight and hearing are more common than in the normal. Congenital cataracts are frequently seen in lower grade defectives. Cataracts of age also occur with frequency and usually at an age younger than in normal. Nystagmus is often found. Strabismus is common. Deafness is not unusual. Middle ear infections are frequently found and are extremely resistant to treatment. Teeth tend to show the results of poor dental hygiene and poor tooth structure itself. The poor tooth structure is usually in the form of anomalies of enamel evidenced as pits, erosions, fissures, or abrasions, and appear to be the result of environment rather than inherent constitutional weaknesses. Many of the tooth anomalies seen can be attributed to the lack of calcium in the maternal diet during pregnancy, as well as to inadequacy of diet during the first year of postpartum life. If the defective is institutionalized early or has been subjected to proper care in a good environment, tooth structure tends to approximate the normal. The patient may even have teeth as sound and good as those of the normal individual. The mandible may show calcium deficiency and often is smaller than normal due to early loss of deciduous teeth with resulting receding chin, great overbite, and other forms of malocclusion. Epileptics and idiots may have the habit of grinding their teeth and may show marked attrition

even in the deciduous teeth. Cleft palate seems to be met with less frequently than in the normal person. The type of dental arch encountered seems to show family tendency rather than any particular regard to mental defect. Poor dental hygiene may show increased tendency toward gingivitis and resistance to treatment. Respiratory and circulatory organs are roughly in the normal range on physical examination. X-ray examination usually reveals an increase in the normal lung markings and evidence of more or less chronic upper respiratory infection. There is a marked lability towards tuberculosis. The genito-urinary organs may be normal, hyper- or hypo-developed, depending on the endocrine balance. Unilateral cryptorchidism is often encountered. Gonadically, the idiot usually is of infantile development. Secondary sex characteristics depend primarily on the gonadal balance, and vary throughout the entire range from hypogonadism to hypergonadism. Pseudohermaphroditism is occasionally encountered. Neurological examination may or may not reveal anything of importance and will be essentially normal with the usual tests performed on the great majority of mentally defective individuals, showing positive evidence only when there has been distinctly localizable damage.

Laboratory study does not, at the moment, offer much assistance in the line of clinical recognition. X-ray of the skull is of little or no value. Ventriculogram and air encephalogram may give supporting data to what is usually already obvious on physical examination. Electroencephalograms have not as yet been sufficiently standardized to prove of too great assistance, except as confirming data and in pointing out associated cerebral dysrhythmia, with or without apparent convulsive seizures. The Wasserman test as seen at this School is invariably routinely negative. Blood counts usually show some degree of mild anemia. Sedimentation test may show a normal or increased rate. In summarizing, we can say that the clinical laboratory at the moment has little to offer in diagnosis.

Family History: The effect of environment upon the mentally deficient must not be minimized, for it plays a consider-

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able role in his eventual development. The family history is important, for there occurs the joining of the inherited and congenital factors with the environmental factors. If the parents are mentally defective, it can only be expected that the economic status of the family is marginal or dependent, and there will be more mouths to feed than money to feed them with. The niceties of life may be minimized and the so-called luxuries reduced to nil. Both parents may show chronic dietary deficiency. During the prenatal period, the mother's diet may not be totally desirable or adequate. Prenatal care is often lacking, medical care at partum minimal, and the postpartum care rudimentary. As an infant, the defective may find his environment more filthy than clean, and his diet unsound and nutritionally lacking. As a result of the general lack of care, physical size, weight, and teeth are affected.

In approximately fifty per cent of the cases encountered at the Polk State School, the family history reveals insanity, feeble-mindedness, epilepsy and its equivalents, or the general socio-economic inadequacy characterized by alcoholism or pauperism. They are ne'er-do-wells of society.

Criminality *per se* does not appear to be a factor of great importance. Criminal history, where obtained, is suggestive rather of the defective intelligence of the family and usually includes such crimes as incest, desertion, or petty larceny. Intermarriage appears to be a positive factor, but here again is likely more properly an index of underlying inadequacy. Syphilis does not appear to be a factor out of proportion to that encountered in the normal population.

The occupation of the father tends toward the unskilled or semi-skilled types of work. The level of social achievement of the siblings is usually low. The neighborhood is often less than good and the home life limited in extent. The death rate of the siblings may be high.

If, however, the family background is economically good and the defective has been exposed to good care and reasonable opportunity, he frequently will appear more intelligent than he actually is. He may absorb many of the graces of

living to which he has been exposed. With good food and medical care, the defective tends to approximate his normal brothers physically.

The moral tone of the family is often reflected in the defective. Size of family is, to an extent, dictated by factors other than intelligence alone but, in general, the more defective the parents the larger the family.

Personal and Developmental History: Personal and developmental history is likely to be incorrect unless the mental defective in question is a child. Too often the information is not remembered long, and especially so if the informant is defective himself. Birth history may give evidence of prematurity, prolonged labor, difficult or instrumental delivery. Jaundice during the early days of life is sometimes reported and possibly important because of the Rh factor implications. Convulsive disorders may be reported, occurring in infancy or the first several years of life, with or without repetition. Sometimes epileptic equivalents can be unearthed with careful questioning. Careful and diligent search may reveal history suggestive, in retrospect at least, of an encephalitis very often associated with measles, whooping cough, or chicken pox. In fact, history of any illness or any injury before the age of five or six years should be carefully studied. Frequently, teething is late. The age at which walking and talking were begun is an important index of retardation, and these activities may be delayed for an extremely long period of time. Considerable discount must promptly be made of parents' statements, as some will grasp at the first faltering step or the utterance of the first sound of the child for evidence of his ability to walk or talk. In general, walking does not occur until the individual in question has passed the mental age at which the normal youngster would have walked. Talking is usually still further retarded and may be lacking, even though the individual has a good understanding of words and ability to follow commands. From time to time the defective may not talk although fully capable of doing so; it is almost as if he felt little satisfaction was to be gained from that activity. It may have been

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noticed that he did not sit up, play with toys, or develop at the usual age, or that he was backward and different from the other babies in the family. Ability to dress himself at the usual age is generally lacking. The ability to button buttons develops after the ability to unbutton them: the ability to tie shoe strings does not appear, usually, until much later than with the normal. The matter of toilet training is important, and lack of it at the normal age of toilet training is the rule. Lack of toilet training after the age of three years should be considered as abnormal. Control of the bowel is acquired first; usually, nocturnal control of the bladder is acquired last. Occasional coprophilia is encountered in lower grade defectives. Coprophagy is occasionally encountered and, if persistent, may cause extreme emaciation.

The ability to recognize danger varies widely. The simpler dangers, such as a hot stove and the like, are recognized at mental ages comparable to those at which the normal child recognizes danger. Dangers where recognition includes the consideration of some factor such as speed may be totally missed. Masturbation by the child is usually denied by a parent unless extreme, and frequently denied even though evident during examination.

In general, the age at which mental peculiarity manifests itself is proportionate to the intelligence, the most hopelessly idiotic being backward or peculiar from birth, while the moron may not show his deficiency to any striking degree until after he has started in school.

History of School Progress: The history of school progress of the mental defective is a history of repeated failures until eventually the child is passed on age and size and more or less shoved into a corner of the school room to be ignored as far as possible by the teacher. The social status of the family may play a role in the teacher's acceptance or lack of acceptance of the child's limited ability. To a certain extent, also, the teacher's personal feelings concerning mental defectives may influence the picture. She may reject him quickly as a pupil if her feelings against mental defectives are strong. If her

feelings are sympathetic, the teacher may tend to over-rate the child's ability because of the fact that unconsciously she minimizes the defect by forgetting his chronological age. Sometimes she may feel the pupil is not fully applying himself, and for that reason may anticipate more ability than the patient really has.

School behavior may be complacent or disturbing. In general, the young defective starting to school likes school because of its activity. Eventually the mentally deficient child recognizes his deficiency to some degree; his enthusiasm wanes, and he may attempt to gain attention for himself by disturbing behavior. As the hopelessness of the situation becomes more and more apparent, he may show open resentment to school attendance and may become a persistent truant. In a special class the defective has a much better chance of prolonged school attendance, for the class room pace is in keeping with his ability and behavior may remain good. Developmental problems on a psychosexual basis may occur with the defective child as well as with his normal brother or sister. In general, the child's school behavior is a fair index of the adequacy of placement. In discussing school attendance, the defective usually makes no distinction between grades passed or failed, and accepts grade attendance at face value without critical regard for how much or how little learned.

Examination in School Work: Examination in school work will show deficiency beginning first in reading. So often the statement will be made, "He can't learn to read." Inasmuch as reading and writing are both activities requiring the use of symbols, we find these processes retarded because of the mental defective's limited ability to use symbols. He may be able to remember symbols and to recognize words and read them, but at the same time still remain unable to comprehend what the words actually mean. In this manner he may have ability to read without ability to comprehend what he is reading. Spelling ability may be fair because basically it is probably only a memory feat. Grammar is seldom really learned, and grammatical construction dealing with spoken words remains poor.

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Arithmetic, too, being a matter of symbols in its inception, is a point of difficulty. The fact, however, that arithmetic as presented in the early grades is pretty much a matter of simple addition and subtraction of two-figure units may mask the difficulties during the first two grades and not become truly apparent until the third grade.

In evaluating school placement of a mentally defective child, the evaluation must be on the basis of reading ability. It is of paramount importance to note and evaluate the visual and auditory acuity of the subject to differentiate between school retardation due to mechanical or anatomic defect and mental deficiency.

Practical Knowledge: Practical knowledge is deficient in proportion to the degree of mental defect. Study of the subject's practical knowledge gives opportunity to bring out the depths of the individual's general knowledge, to study his acceptance of the world about him and his relationship to current happenings. Probably any series of questions relative to practical knowledge is open to a certain amount of criticism, and justly so. In evaluating practical knowledge, allowance must be made for sex, type of home, and location of same. The funds of practical knowledge should be looked upon as a total only, and not as a series of units or questions and answers right and wrong. Questions concerning practical knowledge should break down into question concerning the patient himself, his family, his local community, his interests such as games or sports, and his general fund of information concerning current history. We find the subject becoming less and less informed as direct personal interest is removed. In the moron group we find such funds of general knowledge increasing with age and experience. The idiot and the low grade imbecile remain somewhat static with no or little general knowledge of the world in which they live. Persistent questioning will usually reveal that there is little inquisitiveness concerning life. The simpler facts of life, such as lightness in the daytime and darkness at night, are accepted without ever for a moment wondering about them. Occasionally a defec-

tive is encountered who has a wealth of knowledge along one single line of endeavor; usually this is dependent on memory rather than intellect. Thus, we find those who can give great lengths of batting averages and those who may show a phenomenal memory for dates.

Economic Efficiency: The importance of economic efficiency is practical only if the subject is teen-aged or over. A defective youngster under fourteen or fifteen years of age very likely has never had opportunity to work outside of the home. When considering the teen-age or adult defective, consideration of economic efficiency is important as it assists in giving a good picture of the defective's limitations, his inability properly to handle money, his persistence, and his stability. The degree of supervision required is not only proportionate to the subject's mentality but also to his age and whatever skills he may have gained through repetition of work. In general, there is considerable inability to engage in prolonged work as interest soon lags. If placed at work above his ability, the defective will show fleeting interest and will then become disgruntled. The defective child restricted from school frequently takes considerable interest and pride in his ability to do more menial types of work around the home, such as washing and drying dishes, dusting, or running the sweeper.

The ability to handle money and to make change is not usually well established below the mental age of nine years, although the desire to barter and trade frequently runs high. The matter of profit is of little concern as long as the turnover is brisk. In an institution it is not unusual to find a defective buying safety matches by the carton and then selling them by the box with absolutely no profit, or doing the same with packs of chewing gum, which he sells by the stick. If the defective is bright enough to trade in some standard article of greater value such as candy bars, he invariably sells at prevailing market prices. Trading ability usually is proportionate to the degree of mentality, and we find the brighter defective usually making a dupe of the less intelligent. Items made by defectives for sale, such as Christmas wreaths of ground pine, match-

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stick inlaid lamps, and fancy work, are sold by the defective at very low prices because of his inability to evaluate the charge for time and labor.

Social History and Reactions: Socially the mental defective is always the underdog, rejected by children of his own age, eventually somewhat resented by his own siblings, and sometimes by his parents. He instinctively chooses as associates younger children approximately his own mental age. He is easily led by others and seldom is a leader even when playing with younger children. His interests are simple in nature. He may spend considerable time looking at pictures and listening to the radio. If he reads, his reading will include numerous comic books. He is a collector and saver, and his pockets contain a wealth of materials—string, buttons, burnt match sticks, old pictures, and items of similar ilk. Generally his play is not constructive, and the level of play approximates his mental age. He is frequently teased by others, and in return is often quarrelsome and cruel to persons and animals smaller than himself. He is emotionally unstable and essentially unruly. In general, his emotional pattern reflects the behavior he has observed in those with whom he has associated, and the degree of sympathetic understanding he has received. He acquires pets quickly and often adopts all the stray dogs and cats that come his way. Occasionally, he may show some actual ability in raising chickens, rabbits, or other small creatures. He may be socially unacceptable because of his inability to live by the family's standard. Often he is the overgrown healthy-looking individual so much larger than the others with whom he plays. He enjoys child-play despite his mature appearance. Often he is looked upon with suspicion by the parents of the children with whom he plays.

In general, the higher the standard of the family socially, the less probability is there of the defective making an adjustment, for the boundaries of his social competency are so confining and his limits are frequently unacceptable to the others in the family. Where other children of normal intelligence are in the family, very often the defective member is a source

of constant and growing difficulty. The normal children frequently are unable to understand as youngsters why they are not allowed to do the same things the defective child does. They resent his intrusion upon their play and his general destructive abuse of their belongings. They later become embarrassed by his presence in the household and the unkind jibes of their playmates. The parents, also, may share this resentment, magnifying the proportion of time spent in his supervision. If there is domestic discord, the defective may be injected into it. In general, the mother is more defensive about a defective youngster than the father, and she is quick to be over-critical of all points of care which may be given the youngster.

Moral Reactions: Infractions of the moral code of which the mental defective is guilty break down into three categories—lying, stealing and destruction, and an abnormal interest in sexual matters. He is seldom viciously assaultive. The defective rarely lies maliciously or with a direct purpose of hurting another person. If in trouble, however, he will lie protectively, hoping thereby to cast blame on someone else or to divert attention from himself. He may lie imaginatively or purposelessly, as will a child in phantasy. In most instances, persistent questioning will eventually cause him to admit the truth, but on some occasions he may reach the truth only by deviation through one or a number of other prevarications. In general the defective reflects better than the normal person the moral training he has received and, once thoroughly trained, does not usually quickly deviate from that training. The matter of stealing again reflects the type of training he has had. As a rule, unless being used as a tool, the defective does not steal more than he needs, although he may steal items for which he has no particular use and which he may give away to his acquaintances. The desire for possession is strong, and the spirit of largess may be equally developed. He may be openly and wantonly destructive and destroy property without any particular reason for having done so. In like manner, he may be guilty of pyromanic activity even though his own life may

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be thereby endangered. In a good supervised environment he may readily show considerable honesty. The spirit of justice often is extremely high, and if caught in his acts he recognizes the justice of punishment and, once having endured his punishment, feels he has paid his debt and obligation, even though he may show no repentance or any moral precept for future action.

In general, the sex drive is uninhibited rather than excessive. Usually the drive is narcissistic in the idiot and not truly heterosexual below the moron level. Sex perversions are frequently encountered, not only as a result of actual lack of inhibition but also as a result of inducement by others. Sex perversions as encountered are probably present because of accessibility and ease of practice, rather than as a matter of preference over normal sex behavior. Sex activity with animals is occasionally encountered, but I believe is less common than sex activity involving another person. Sadism is not important. The defective's sex life is probably on a pleasure basis only, without any great degree of phantasy. Probably there is a considerable glandular role in the matter of sex perversions, as we have noted that persistent sodomists in our group of patients invariably have distinct effeminate configuration. The male defective in his sex desires is usually not aggressive to the point to which he will approach a woman with sexual interest. When sexual assault does occur, the action is usually directed towards a younger child. The female defective, by virtue of her suggestibility, constitutes a threat to herself as she may be easily seduced by any unscrupulous individual. A history of more than one illegitimate child born to a woman might almost be *prima-facie* evidence of mental retardation. Exhibitionism as evidenced by the mental defective is usually not true exhibitionism, any more than that met with in the normal child.

It is unlikely that the true mental defective ever becomes a true criminal because of the fact that his lack of mentality closes the door to such a career. Homicide and murder are not acts to which the defective usually reverts. If he does kill,

it is not an act of planning, but a passion of the moment, or accidental. It is true he may become a thief in a petty manner but he is unsuited to the more highly skilled types of crime. He cannot become a first class pickpocket because his dexterity is insufficient. He cannot become a "con" man because he does not have adequate mental alertness to paint a convincing picture. He does not have the ability to become a second-story man nor does he have the judgment and discrimination to permit him to be a successful housebreaker. He has not the money sense nor the writing ability to become a forger. To the female, the only avenue in crime really open is that of prostitution. Even in this profession she can hope for little, as her lack of personality must make her undesirable to any except the most carnal. If the defective enters crime, his career is short, for his stupidity must quickly bring him to early detection and penalization.

Psychological Tests: Psychometric testing is of course desired in making any formal diagnosis of mental deficiency. Despite the undeniable value of formal tests, one should not place too much emphasis upon tests alone in making a diagnosis, as psychometric tests are tools only and not infallible and God-given fiats. One positive test for sugar does not warrant a diagnosis of diabetes, nor does one low psychometric test result alone warrant a diagnosis of mental deficiency. Evaluation of a psychometric test presupposes the ability and skill of the tester, and the value and accuracy of the test is proportionate to the experience and ability of the tester. For that reason, amateurish attempts to give formal psychometric tests should be discouraged. In general, when no formal testing is available, a fairly reliable estimate can be made in younger individuals by comparing the defective's behavior and ability with the normal developmental behavior, and estimating from this the probable level of mental activity.

The following tests are used at the Polk State School and are grouped according to type:

A. TESTS OF INTELLIGENCE.

I. Revised Stanford-Binet Intelligence Scale, Forms L and M:

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- a. The test is an age-scale designed primarily to determine the general level of mental ability. The forms are different in content but equivalent as to difficulty, range, reliability, and validity. On the whole, Form L is used in this School more frequently than Form M, the latter being employed for retesting purposes. The end result is a mental age which can be converted into an intelligence quotient. The standardization of this scale was based almost entirely on children and the material is of interest to children. Consequently, its use with adolescents and adults, except with those of very low ability, is questionable.
- II. Hayes Revision of the Stanford-Binet Scale:
 - a. This form of scale is used with the blind.
- III. Wechsler-Bellevue Adolescent and Adult Scales:
 - a. Verbal Scale;
 1. This part of the tests consists of five subtests designed to tap the subject's range of information on material that the average person with average opportunity should be able to obtain for himself. In addition, it measures his use of common sense, his ability to evaluate past experience, and to generalize and think in abstract terms. The end result is an intelligence quotient.
 - b. Performance Scale;
 1. This is made up of five subtests which require the subject to do something rather than talk about anything in abstract terms. It points up the subject's speed, accuracy, and his ability to discriminate and analyze. The end result is an intelligence quotient.
 - c. A full scale quotient of both parts of the test can be obtained, and the individual should be considered in the light of this result. However, the breakdown of this quotient into abstract and concrete entities is particularly valuable when used with mental defectives. With the exceptions of epileptics, those with psychotic tendencies, and older patients, the mental defective will, on the whole, show a higher performance than a verbal quotient. The test has been standardized on adolescents and adults and the content is interesting to older people. It is our opin-

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ion that when a subject is being considered for parole, particularly when he is going to have to compete with the average person who has an average opportunity, the Wechsler-Bellevue Scale is a more valid measure of his global intelligence than is the Binet.

IV. Grace Arthur Point Scale of Performance, Form I:

- a. This is a measure of non-verbal intellectual capacity and much of its value lies in the qualitative observations that can be made during a performance. It is a supplement rather than a substitute for the verbal scale, and may be used in cases where verbal tests are inadequate because of language handicap or sensory defect. The end results are performance age and performance quotient.

B. TESTS OF VOCATIONAL APTITUDE

I Minnesota Paper Formboard Test, Revised series AA:

- a. This test has a relatively high validity for prediction and measurement of various grades of proficiencies of mechanical ability. It purports to measure the speed of recognition of similarities between forms. Norms are available for age, educational and occupational groups.

II. Pennsylvania Bi-Manual Worksample:

- a. This is a test of motor skills such as finger dexterity, gross movements of arms, eye-hand and bi-manual coordination. It combines the basic elements that are inherent in a relatively simple work situation. Norms are set up for both sexes for age groups from 17 to 50 years, the samplings being obtained from a Trainee Acceptance Center

III. Minnesota Rate of Manipulation Test:

- a. A test of motor skill which measures speed of gross hand and arm movements. It has been used in determining aptitudes of semi-skilled factory workers such as food wrappers, packers, etc. Since this aptitude matures early, the norms are applicable to adolescents. Standard norms are derived from scores made by a large sampling of adults gainfully occupied in an urban area.

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IV. Minnesota Mechanical Assembly Test, Short Form 1 and 2:

- a. This test measures an individual's "mechanical intelligence", or his ability to put together twenty different simple mechanical devices as a monkey wrench, bicycle bell, electric wire and plug, and a lock within a specified time. Caution should be exercised in interpreting the scores of adults who have, through previous experience, become familiar with devices similar in principle to those on the test. The scores in such instances are determined only in part by endowment. Norms are available for age and educational groups.

C. TESTS OF PERSONALITY — the following tests represent the projective approach to the structure of the personality, and are considered more effective for use with the mental defective than the personality inventories. The latter presupposes an ability to read and comprehend the printed word, an ability which is often lacking in our patients.

I. Rorschach Psychodiagnostic Test:

- a. This is a series of ten ink-blot, some of which are in black and white and some in color. The subject "projects" into these meaningless symbols the things in his environment and within himself that are meaningful to him. By this means the test brings to light certain aspects of intelligence, thinking, imagination, phantasy life, and emotional stability. Its value lies in its ability to predict whether or not the personality will develop neurotic or psychotic tendencies under undue strain.

II. Thematic Apperception Test:

- a. This is another projective technique, consisting of a series of twenty photographs and pictures representing life situations. The last ten are much more bizarre in content than the first. The subject projects himself into these pictures by identifying characters, setting up relationships between them, and stating the outcome of those relationships. This method purports to reveal the present needs and motives of the individual, as well as the effect that environmental press has had upon him. It is particularly

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valuable when used with adolescents who have developed delinquent tendencies.

The adult defective differs extremely from the general picture we have attempted to give. He is more difficult to classify when recognized, because time has given him a wider scope of interests and a wider range of knowledge. As an adult he is usually economically inadequate and employable only in some minor position or during boom times. He becomes a relief recipient during the first days of depression, and once under the arm of paternalism is one of the last to shed its assistance. He lives resented by the community and confused by his own lack of adjustment. He is the victim of every crack-pot and produces a continual stream of crack-pot ideas of his own. He continually seeks green pastures. Occasionally he may become an inveterate itinerate, spending the winter months in a county home and the summer months on the road. If he marries, he seldom marries above his own level of intelligence, and the home quickly becomes a slatternly abode dubiously blessed with numerous slovenly offspring.

No consideration of institutional mental deficiency would be complete without a word of admonition to the workers who are the liaison officers between the family and the institution. An institution for the mentally defective represents a source of assistance to the defective individual, his family, and the community. It seldom represents all three equally in any one instance. The family should not be deluded into thinking that institutionalization is going to eliminate the mental defect, and they should not be given hopes beyond reasonably justifiable anticipation. The family should not be encouraged to anticipate restoration of the child's mentality when "he becomes older", nor encouraged by unwarranted exaggeration of training when such is absolutely precluded by the degree of retardation. The family facing the prospect of institutionalization of a member because of mental defect is entitled to a frank, honest picture of a child's defect and his continued delayed development. It is better for them to face disappointment at the moment, rather than to cling happily to some hope for improvement

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and then later to be disappointed. Because of the general overcrowding of institutions of this type, the family should be encouraged to await admission patiently, without resorting to undue political, personal, or parochial pressure. A case worker should endeavor to furnish the institution with a true and complete history of the applicant, his family, and his environment in order that the institution may more properly evaluate the application and the relative urgency, as compared with numerous other applications pending.

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THE PRACTICAL TRAINING OF THE FEMALE DEFECTIVE

EFFIE C. IRELAND, M.D.

It is the objective of practically all schools for the feeble-minded to train as large a proportion of their inmate group as possible so that they may make a satisfactory adjustment in the social order. Each institutionalized mental defective represents a problem that the community could not handle. The return of the same individual to the community as an asset rather than a liability is a real achievement.

All institutions for the feeble-minded have varying numbers of inmates with such limited capacities, or such unstable personalities, that indefinite custodial care remains the only solution. The training of this group to the extent of their limited capacities tends to give a more smoothly functioning organization, and makes institutional community life more pleasant for all concerned. But, it is the salvage of the defective who still presents some potentialities, hidden though they may be—the girl frequently rejected by the home, certainly rejected by the community, a failure in school, with resultant feelings of inferiority, lacking in social competence, lacking in security, emotionally immature, and with anti-social tendencies—it is the taking of this material, the breaking down of wrong habits of thought and action, the building up of better social values and conduct, simultaneously with the teaching of some means of earning a livelihood and independence, that presents the real challenge.

Limitation of intelligence is only one of the factors responsible for a girl's commitment to an institution. Emotional instability, persistence of childhood standards of conduct, an undeveloped sense of responsibility, compensatory reactions to failures and inabilities, amorality due to environmental inadequacy, lack of insight and judgment and, in some cases en-

grafted on all these things, actual criminal tendencies, all result in social failure. Her training must therefore be social and emotional, as well as mental. In constructing any training program for the mental defective, one must bear in mind that he is dealing with limited capacities of varying degree and personalities of wide divergence. These range from the actual psychopathic personality to the quiet, cooperative girl, who is literally too suggestible. In all of them there is present a lack of judgment and reasoning ability to profit by experience and lack of, or limited, ability to plan or foresee results. The learning process is slow and proceeds by constant repetition. Success must be noticed and praised, and failures passed over as lightly as possible (too much attention has been given them in the past). After all, the development of proper work habits and attitudes is, in the end, more important than the specific skills. Various employers will have different methods and will be willing to do some teaching themselves if the girl is willing to take suggestions and corrections, is reliable, and has a pleasing personality.

The higher grade defective has, in most instances, been involved in various delinquencies prior to institutionalization—sex delinquencies most often but, not infrequently, in addition, such offenses as robbery, burglary, forgery, larceny, receiving stolen goods, breaking and entering, assault and battery, in some instances assault with intent to kill, and even second degree murder. Of course, the more serious offenders really do not belong in the training school for mental defectives, but they must be removed from the community, and until special provision can be made for them, the training school is the only place open to them in many states. Be that as it may, coming from other institutions as many do (correctional institutions, detention homes, jails, the women's penal institution), and with the feeling that they have already served their time, their attitude is apt to be one of resentment at continued institutionalization. This situation is not at all improved if the person who accompanies the girl to the institution, in order to have a more tractable travelling companion, tells her that she "won't

have to stay long", or that she is taking her to see her babies, or (as one did in a recent instance) brings the baby along with the girl and leaves it to a staff member to effect the separation.

The situation may not be quite so trying when the girl is brought directly from her home, but it is still a difficult adjustment. No matter what the squalor and poverty from which she comes, it is still her "home" and its inhabitants are her "people". She is resentful, suspicious, and fearful of what may happen next.

Taking these things into consideration, it is quite evident that there will be a period varying in length with the individual case (the less trauma, the shorter the period) when about all one can do is let time, understanding personnel, and some other well adjusted inmates help heal the wounds. It is not the time to force issues—unless there is actual physical violence that must be restrained.

A new girl is ordinarily admitted to the hospital or to a separate admission building where she remains for a quarantine period of three to four weeks. During this period, short, friendly visits by members of the staff are helpful to her and to the staff who must plan for her. If she has the opportunity to be with other adjusted inmates from time to time—for instance, with the chronic patients who are able to be up in the sun, parlor playing games, reading, or busy with occupational therapy—this happy atmosphere, together with the kindly care of hospital aides (inmate helpers) and nurses, will eventually dim the resentments unless they are so deep-seated as to be pathological. During this period, physical examinations, immunizations, etc., may be done, but it is not the time for psychometric testing. This should be held in abeyance until the disturbed period is over and the girl is definitely on the way to a satisfactory adjustment. Friendly visits by the psychologist will pave the way for these tests later, however.

Of course, no intelligent plan can be made for the girl until she has been carefully studied: her past experiences and her reactions to them, as revealed by medical, social, and psychological studies explored. The psychologist must use varied

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techniques in order to get a comprehensive picture of her capacities and potentialities. In addition to the usual verbal, non-verbal, achievement, and special tests in general use, the projective techniques can be of great value. The Rorschach and the Thematic Apperception tests give not only a picture of present functioning, but bring to light basic personality structure not shown on most other types of tests.

In making plans for the girl it is well to bring the girl into staff meeting for interview. Aside from any additional information which may be acquired by the staff at this time, she is given the assurance that the staff are interested in her personally, as an individual apart from all the others, and are sincere in their desire to help her.

The training of the mental defective naturally falls under three headings:

1. Academic: the increase of practical classroom knowledge to the limit of her ability.
2. Industrial: to provide a means of earning a livelihood.
3. Social: the teaching of proper relationships with others.

If, on testing, the educational age is found to be below the mental age, as it is in most instances, the girl should by all means be placed in school. Many training schools limit the academic classes to those under sixteen years of age. A few make it eighteen. It has been the experience of the staff at the Laurelton State Village that the older inmates appreciate the opportunities offered by the classroom quite as much, if not more, than the younger ones, and reap as many benefits from them. The work must, of course, be kept at a practical level. The mental defective has enough difficulty learning the things she will need to know to take her place in the community without cluttering up her limited capacities with facts and figures she will never need nor use. She should be able to read signs and directions (and to understand what she reads), to use a telephone directory, to consult the dictionary, to read letters, to obtain information from newspapers and magazines, and over and above this, to do some reading for pleasure. The teachers should aid individual members in their

classes in the selection of books from the library. A girl who, if she has done any reading at all prior to institutionalization, has read only "True Stories" or "True Romances", needs considerable direction and training. The library, of course, should be open to all inmates and a full time librarian who can give this guidance is a definite asset.

Attention should be given to speech correction. So many mental defectives are subject to slovenly or defective speech and some have such a degree of defect that it lessens considerably their prospects for employment. A full time, well-trained speech correctionist is a valuable addition to any staff.

In number work the individual should be able to count and read figures including small fractions (she cannot follow a recipe otherwise). She should be able to make change, compute wages, etc. She should be able to measure with a rule and recognize measures—pint, gallon, peck, pound, inch, yard, etc. Whatever number situations are common occurrences in daily life should be taught in the classroom.

She should be able to write legibly; to write a friendly letter, a business letter, a letter applying for a position, etc.

Health habits should be taught; the physical care of the body including the care of hair, nails, eyes, teeth, correct posture, the value of regular exercise and adequate rest, etc.

It is not within the scope of this article to suggest a curriculum, but it cannot be too strongly reaffirmed that the subject matter must be carefully evaluated and presented in concrete life situations such as the defective will encounter. Classroom instruction must be based on the individual need and not on a scheduled amount of subject matter to be taught. Teachers should have majored in special education or have taken post graduate work along this line.

Mental defectives are much more adept manually than mentally. On the whole, they work well with their hands and like it. They enjoy doing simple routine tasks that would become exceedingly monotonous to one of higher intellectual capacities. They can be trained to do worth-while work in the ranks of the semi-skilled. It would not be possible, nor is it

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necessary, to teach all of the simple procedures that can be mastered by the higher grade defective. As mentioned earlier, if the individual has the proper work habits and a pleasing personality the routine skills can be learned as needed.

A large percentage of female defectives enter upon domestic work on leaving the institution. All institutions with their kitchens, dining rooms, bakery, possibly cannery, laundry, sewing room, mending room, and general institution housework, are especially fitted to give their inmates exceptional training in the household arts. There are definite objectives to be met in this field. The Women's Bureau of the United States Department of Labor has made extensive studies of the household employment situation. In the November, 1940 issue of *Household Employment, An Outline for Study Groups* there is listed for the duties that the semi-skilled worker should be prepared to perform:

1. *Meal preparation*

- Clean and store food supplies
- Prepare food for cooking
- Assist with cooking
- Set the table

2. *Clearing away after meals*

- Clear table
- Scrape, rinse, and stack dishes for washing
- A good job of washing dishes
- Care of tea towels
- Sanitary garbage disposal

3. *Cleaning*

- Thorough cleaning of living room, dining room, bathroom, bedroom, kitchen, and porch
- Knowledge of order of cleaning, and use of vacuum, carpet sweeper, and broom
- Care of different surfaces—tile, waxed floor, linoleum, and rugs
- Washing windows

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Cleaning cupboards

Cleaning kitchen equipment—refrigerator, sink, bread box, and stove

Cleaning silver ware

4. *Bedmaking*

5. *Laundry work*

Assist with the family wash — rinse, hang out, take down

Iron plain things

6. *Miscellaneous*

Answer the door

Answer the phone

This list was drawn up by a household employment committee composed of employers of household workers, employees, and representatives of two placement agencies of one particular city for their own community. However, any individual who has learned to do all these things acceptably will give satisfactory service anywhere.

The girl must understand what is expected of her and that in order to secure and hold a job she has to measure up to standards. One should always keep in mind that, regardless of the previous experience a girl may claim to have had in any particular unit, she must be started on the simplest task in that unit first, progressing to the next tasks in order of difficulty only as she has demonstrated proficiency in the task at hand. The assignment of too difficult a task in the beginning may result in failure and compensatory reactions to inferiority. A careful record should be kept of each girl's accomplishments, and when she has mastered any complete unit—for instance, when she can do well all of the various types of work required in the kitchen from the preparation of vegetables to the cooking and serving of food—she should receive a certificate of proficiency for the work in this unit. This is just as important as the certificate received when she has completed the maximum amount of school work of which

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she is capable. It furnishes a real incentive and becomes one of her proudest possessions.

An important pitfall must be avoided. When a girl has become a proficient cook, or laundress, or seamstress, there is sometimes a tendency to keep her in that particular unit. She has become a valuable person and the routine work of the institution will function more smoothly if she is retained rather than moved on to the next unit and a new girl brought in to be trained. Of course, it will; but the injustice to the girl is obvious. When she has become such a valuable worker in any particular unit that she can't be moved from it, she certainly could be earning her living outside the institution in the same type of work. The head of each unit should furnish regular reports on the progress of the girls in her unit, checking up on behavior, neatness of appearance, punctuality, courtesy, honesty, industry, ability, etc. When any girl has completed a unit satisfactorily, the head of that unit should make the recommendation that she be granted her certificate of proficiency.

Cooking and laundry work are usually done on such a large scale in an institution that, while a girl on completing these units could work in a commercial laundry or a restaurant, she knows but little of the work as it is done on the family scale. There should, therefore, be a special home-making unit with a well-trained vocational teacher in charge who, in addition to teaching cooking and laundry work as it is done in the average home, could give the girl some knowledge of the foods they cook, instructing them in the selection of foods, teaching them something of balanced diets, food costs, and budgets. In this day of electrical appliances, this course should really be a post-graduate course in the use and care of the equipment used in the home. While neatness and cleanliness are naturally stressed everywhere in the institution, special emphasis may be placed on them here, together with suitability of dress and the unsuitability of wearing jewelry and fancy "hair do's" while "on duty." The teacher should also train them in other home-making activities, giving instruction with

regard to the various grades and prices of materials used for curtains and drapes, towels, clothing, and linens, and advice in their proper selection. It is a good idea to make this course a "finishing course", following the completion of the other units.

By the time the girl has completed her training, even though there may be no special industrial shops and the routine institution work alone is relied on for a training program, she should be able to earn her living by working in a commercial laundry, a restaurant (either cooking or serving at table), as a seamstress, mother's helper, or as a maid in a private home. Many girls particularly like work on the farm, in the dairy or in the poultry unit. While these need not be required work units, the desire should be encouraged when found and recognition given for these units also. These girls make excellent helpers in farm homes.

The hospital offers valuable training as nurses' aides. Knowing how to make a hospital bed, give a bed bath, take temperatures, give enemas, etc., never comes amiss, no matter what work one enters upon later.

The most important part of a girl's training is, of course, the social and moral. This is where she has failed grossly in the past. In many cases, the academic and industrial training have been completed, and still the girl cannot be returned to the community because she has not been able to adjust socially. She must have self-respect and self-confidence, be happy and cheerful, be interested in and considerate of others. She must acquire self-control and learn to say "No" when the occasion demands it. The easy-going girl who agrees with everything and everybody and is never a disciplinary problem is much more of a risk in the community than the girl who indulges in occasional temper tantrums and causes trouble from time to time by insisting on having her own way. The latter can be guided and trained; there is little to work with in the former.

Having been brought into the institution and thus removed from the environment in which she failed, as the girl

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finds herself with others of similar mentality and the unfair competition ended, she will naturally lose some of the feelings of inferiority with the passage of time. The regaining of self-respect and self-confidence can be aided in various ways, however:

1. Improvement in personal appearance with special attention being given to hair, nails, and make-up. A "beauty-shop" is a great morale builder.

2. Recognition and commendation for the task well done, no matter how trivial.

3. Dramatics and the like help a girl to acquire poise and self-confidence. The school clubs with their elected officers and student programs—under teacher supervision, of course—are of great value. Hobby groups—finger painting, puppet shows, nature study, stamp collections, etc.—broaden the individual's development.

4. Group activities—organized play such as basketball, volley ball, and similar activities—not only improve posture and the physical body in general, but bring out leadership and give training in good sportsmanship. A good athletic teacher is an essential member of the staff.

5. Responsibilities should be increased as training progresses. This may be carried to the point where a modified form of self-government may be initiated. The first council should, of course, be appointed, as many of the girls will not understand the qualities needed for good leadership and an election would result in the choice of the most popular, but not necessarily the most dependable, girl. The council should meet at least once weekly with the matron of the cottage and a social worker or other understanding staff member present in the capacity of advisers. Cottage problems and needs should be considered and brought before the council for reprimand, for infringements, or commendation for good work and conduct. The Secretary of the Council should keep the minutes. The general morale of the cottage group is raised and the qualities of good leadership emphasized. Incidentally, the system can

be a great aid to the attendants in this period of attendant shortage.

Occupational therapy has varied aims and purposes. Its value for the physically and mentally handicapped has long been proven. It is also valuable training for the new girl who is in the process of adjustment, or too young, or too unstable, to take a sustained interest in the industrial units except the cottage housework. She learns to work in a group. She also learns the satisfaction of creation and the completion of the article which she has created. This work is similarly valuable for the disturbed or actively delinquent girl who can dissipate her energy by working on a loom rather than by breaking chairs or window panes. The skills learned in arts and crafts are, in addition, excellent training for leisure time activities, and may also be gainful.

Music is an exceedingly important part of any training school program. The mental defective loves to sing and dance and, with patience, can be taught to play various instruments sufficiently well for the organization of an orchestra. To be a member of the institution chorus or band is an honor, indeed. School spirit and loyalties are developed as the band or chorus entertains in neighboring communities. The presentation of an operetta or some other special program to which the public can be invited is a very worthwhile project. Academic teachers, the athletic director, and the music teacher, as a rule, enjoy working out together the programs for such special occasions as Easter, May Day, Thanksgiving, and Christmas.

The innate need of religious training is well recognized and provided for by all institutions. One service a week, however, would not seem to be sufficient if religion is really going to prove a force in shaping the life of a mental defective. Attendants can usually be found who are willing to teach Sunday School classes or to give instruction to the Catholic girls. A cottage service on Sunday evening, in addition to the usual weekly community services, gives the girl the opportunity of being a really active participant. Private devotion should be encouraged. A girl should have the opportunity of uniting

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with the church of her choice after she has demonstrated by her conduct over a reasonable period of time that she understands the pledge she is making and is sincere in her desires. All faiths must have opportunities for their own form of worship.

Directed recreation, as has been mentioned earlier, is constructive as well as enjoyable. Organized activities conducted by a physical education instructor, music, movies, and planned programs, are a part of most training school programs anywhere today.

But what of the time spent in the dayroom? Gone is the day—or gone it should be—when the inmates sat with folded arms around the walls of the room while an eagle-eyed attendant sat in the middle of the room and watched for infringements of discipline. The alert attendant should mingle with the girls, encourage group games, table games, reading, singing, dancing (there should be a piano in every dayroom). She should make every effort to keep the girls occupied and happy. The dayroom won't look spic and span, but need one ask which is more important?

With so many varied personalities and backgrounds it is only natural that disagreements will arise from time to time. These can be averted if the attendants understand the problems involved and are alert and skilled in handling their girls. A certain small percentage cannot be avoided with the more actively delinquent girl. No one would want to live in a social order without rules of conduct, however. The girls on the whole know and appreciate this fact. They have much more respect for the attendant who is kind but firm and at the same time fair, than for one who lets them "get away with things". Emphasis must, of course, be placed on good behavior and the qualities of good citizenship. Suitable rewards—for instance, additional privileges—may be given for praiseworthy conduct. This does not mean to the docile child who never causes any trouble, but to the girl who has to exercise self-control and of whom it requires an all-out effort to maintain satisfactory standards. Her successes must certainly be recognized as an

encouragement to further effort. A girl is proud of having her name on the honor roll for the month. She may be permitted to attend other basketball games in addition to the ones participated in by her own cottage; she may be permitted to attend an evening movie at the local theater with an attendant; or to do housecleaning work in the nearby community for a day or two (this is a highly coveted privilege). Infringements, of course, cannot be overlooked, and deprivation of certain privileges may be necessary at times.

The attendants have the closest and most constant contacts with the inmate population. Their choice should be a matter of great care. Mental defectives are great imitators. The noisy, gum-chewing attendant, with the too short dresses and too much make-up, will have her following and ardent admirers of this undesirable pattern, just as the quiet, mature, well-mannered, sofe-spoken attendant, who dresses neatly and uses moderate, well-applied make-up, can wield a tremendous influence in the right direction. It is obvious that the conduct of all employees should be above reproach. Everyone with whom the girl comes into contact is an example to her, and one employee with questionable standards can do a great deal of harm.

In conclusion, no staff, however well chosen, and no program, however carefully planned and executed, can possibly return 100% of these higher grade defectives to the community. For some, the very unstable, and the very delinquent, indefinite institutionalization may be necessary. Of the number returned to the community a certain percentage will not make good and must be returned to the institution, but the number who do remain in the community, and who prove satisfactory citizens, make the training effort definitely worthwhile.

It is the policy of most training schools to place a girl on parole at the conclusion of her training period and carefully to supervise her adjustment in the community until such time as she seems to be getting along quite satisfactorily and all indications point toward continued success. If a system of

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community supervision could take over where the institutional supervision ceases, the number of successes would unquestionably be considerably increased.

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INTRODUCTION

The subnormal girl who makes her appearance in a custodial or penal institution has been sent there as a result of her nuisance value to the community from which she comes.* Perhaps all or nearly all subnormal girls can be termed emotionally unstable at the time they are institutionalized and during their initial adjustment and orientation to the regulations of institution living. No girl likes to be taken out of the community and placed under custodial care. She may be passive, aggressive or depressed. She is always to some degree upset. After a while the majority of these girls somehow shake down and make a more or less favorable adjustment to the institution. Quite a few attain security by being removed from unfavorable home or community surroundings. In the institution they no longer feel they are the stupidest or most inadequate child in the family or pupil in the classroom. Others accept institution living out of expediency and make the most of what they consider to be a temporary arrangement. They bide their time and get some enjoyment out of work, training, and especially from new friends.

But there is always a minority group among these institutionalized girls who remain as maladjusted in the institution as they did in the community. In fact, some of them become progressively more disorganized in their behavior as the years go on. They may be unhappy, impulsive, moody, ready to fight at the slightest provocation, resistive to authority, over-

* We shall deal only with high grade subnormal girls of moron and borderline intelligence. Lower grade defectives present very special problems of management and need to be treated separately. Also we shall limit our discussion to problems of adolescents and adults, not young children.

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demonstrative or unduly silent. In a great number of ways they show their discontent. It is these more or less permanently emotionally unstable girls whose names are "known" throughout an institution, whose caprices become legend among attending physicians, matrons, attendants, teachers, and other inmates, and who are our concern in the present discussion.

BEHAVIOR PATTERNS

The patterns of behavior of these emotionally unstable girls range from the ones that can roughly be characterized as delinquent to those that are more highly psychopathological, although this differentiation is perhaps too arbitrary. Some of these girls do behave, however, more as do delinquents in the community, by defying authority, stealing from others, escaping or attempting to escape from the institution, staging a rebellion, breaking property and attacking others. On the other hand, they may act in a manner more characteristic of psychopathological behavior than straight delinquency. They may daydream for long stretches at a time, masturbate before others, make frequent sexual advances to girls, chatter incessantly, do pathological lying, become extremely restless or abnormally negativistic. A brief description of a few cases of the emotionally unstable subnormal girl will give us a picture of how varied her nuisance value is to the institution authorities.

Anita and Ruth are morons with a Terman I. Q. of about 65 each. Anita is 48 years old while Ruth has a chronological age of 20. Anita has been institutionalized off and on for twenty years, Ruth continuously for eight years. They are both hyperactive, excitable and moody. These girls are very troublesome in their cottages, during recreation periods and at work. They are both demanding of attention and very easily annoyed by other girls. They have very few friends. They both like to dominate and show their superiority. They have an institution record of innumerable fights and subsequent punishments. The fights usually start when they are asked by an attendant to do something displeasing to them. Anita is not assaultive

but she becomes profane and abusive in her language. Ruth is not vicious but she strikes out impulsively. On one occasion she knocked an attendant down, breaking the attendant's arm. She has also been known to injure herself in order to gain sympathy when something goes wrong. She twice pushed her fist through a pane of glass, cutting her wrist badly.

Selma is one of the most severe sex-problems with which the institution has had to contend. She is a 19 year old girl with a Terman I.Q. of 68. Selma has become particularly fond of Negro girls and tries to visit their beds at night or to corner them in a washroom. She cannot stand in line near another girl whom she likes without fondling her. She day-dreams a great deal, so much so that her work has always been done poorly and half-heartedly. If left alone, she masturbates quite openly. Whenever Selma sees a boy or man pass the cottage window, she becomes fidgety, restless, starts biting her nails, or rushes off to the toilet.

Leona is a 21 year old girl of borderline intelligence (I.Q. 77). Periodically, usually just prior to her menstrual periods and sometimes between these periods, Leona becomes extremely belligerent. She threatens to run away and has succeeded on two occasions in doing so. She picks a fight on the slightest provocation, as when another girl shuts off a radio program Leona is listening to, or if she thinks another girl is monopolizing too much space on a bench. When a fight starts Leona becomes so vicious that it has taken two strong adults to control her. On several occasions Leona has threatened to kill or emasculate doctors and male attendants. She is lazy, a poor houseworker, and is an inveterate liar.

ANALYSES OF INDIVIDUAL PROBLEMS

Since the emotionally unstable girl can be so troublesome and wasteful of the time and energy of employees and staff members responsible for her, it is never unprofitable to spend a good deal of time on obtaining and studying the social, medical and psychological data on a particular individual. The analysis of this material should be done as early as possible

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in the girls' institutional career so that guidance and treatment may be carried on with constructive and systematic procedures rather than with haphazard and destructive ones. These girls need more than a routine medical examination and the giving of psychometric and educational tests for determining intelligence level and educational achievement. A special medical examination including neurological and psychiatric procedures can throw a great deal of light on the clinical type presented. It is indispensable to know, for instance, whether the girl has had an organic brain disease, and to what extent her physical organism is functioning normally or is in need of medical attention of one kind or another. It is necessary to know to what degree the girl shows more or less marked psychopathology. All of this sounds like ABC and is well-known to all of us working in the clinical field. One small but important item in the life scheme of an unstable girl can add tremendously to her maladjustment. For example, Leona, one of our examples given above, had a very low basal metabolism which had not been revealed or considered in her first medical examination. Ruth developed severe headaches, which she did not report because she was afraid of medication and of being hospitalized: it was found subsequently that she had very marked astigmatism of both eyes.

The psychological service of an institution can contribute a good deal of information about the personality organization of the unstable girl, her mental efficiency, her special abilities and disabilities, some of the dynamics of her behavior, her aspirations, frustrations, and interests. Psychological techniques, both psychometric and projective, may reveal aspects of behavior not detected in the everyday observation of a girl, and may supply information about the best methods of training and guiding her to a more happy and successful life adjustment.

A. *Psychometrics.* We assume that the unstable girl under consideration has already had a certain amount of psy-

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chological testing as has any girl committed to a custodial or penal institution. What we look for before any further testing is done is what tests already given tell us about the individual. Discrepant test scores are of particular interest to the psychologist. The girl may have been committed on the basis of a rather low score but have done much better on a test subsequent to admission, or vice versa. She may have been poor in vocabulary but high in non-language material, or high in verbal material but very inadequate in tasks requiring eye-hand coordinations. It is more often true than not that the emotionally unstable individual gets a higher mental age on a test like the Terman and a lower mental age on the Goodenough drawing test. For instance, Selma, to whom we have referred already, has a mental age of over ten on the Terman but only seven on the Goodenough. On the other hand, there are quite a few exceptions — those who are unable to handle verbal material, such as reading, spelling, writing, or word comprehension, who do exceptionally well in manipulative tasks, as block design or picture completion tests. One girl of our acquaintance never went beyond the level of second grade work. She was moody and obstinate in her relationships to teachers, attendants and other girls. But, on the Kohs Block Test, she secured a mental age rating of eighteen and the needlework which she did in occupational therapy was admired not only by visitors to the institution but by the general public when a sample of her work was chosen to go on exhibition in a city museum.

B. Projective Techniques. Finding out about the special mental abilities, capacities and talents of the unstable subnormal will help in working out a program for her training and guidance, but even more helpful are the techniques which give us more specific clues about the personality organization of the girl than can intelligence and performance tests. Tests and tasks which allow the subject to manipulate the material presented to him in a less restricted but more individual manner and with no emphasis on right and wrong responses are called Projective Techniques. In these tasks the individual is

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free to adapt the material to his personal interests and needs, and to project his own attitudes and wishes into his responses more fully than he can in more formalized psychometric examinations. The material is much less specifically defined than in the psychometric test. The Rorschach Ink-blot Test and the Thematic Apperception Test are among the more thoroughly systematic techniques of this kind now available and are suitable for use among subnormal individuals, particularly those who are disturbed.

The Rorschach is valuable in revealing to what degree and what type of psychopathology is superimposed on mental deficiency, *i.e.*, anxiety, hysteria, obsessive or compulsive trends, depression, schizophrenia or organic brain involvement. It may also indicate that a girl is not as mentally deficient as her I.Q. score suggests, but rather that her emotional difficulties have been so severe that her mental level and efficiency have been greatly reduced. For instance, Mabel, 25 years old, was institutionalized for wandering the streets as a prostitute. Her life in the institution was decidedly non-adaptive. She threatened continually to run away and she regaled other girls with stories of her career in the community. On a variety of psychometric tests her I.Q. scores ranged from 50 to 55. On the Rorschach Test she described card VIII as "two lions climbing up a mountain where there are woods, a forest of pine trees and underneath a flame (orange-red blot). Sometimes you know woods start burning." In card II she saw a white vase with a painted ornament on it, and up at the top "a person's liver with blood streaks in it." This girl no doubt has no very high degree of intelligence but her imagination is certainly higher than that of a low-grade moron. She has, of course, a great deal of anxiety and is without question a severe psychoneurotic. Another unstable girl of 15 who was the despair of her school teacher in the institution because of her preoccupation with drawing pictures rather than doing her school work, said of card V on the Rorschach (the card resembling a flying butterfly or bat), "That is a black wave coming out of the sea. You have to run to get out of its way". This response and

other similar ones (responding to the achromatic colors) first suggested that this girl was suffering from severe psychopathology taking the form of depression.

The Thematic Apperception Test, particularly the old series and the first ten cards of the new series, is a useful tool for the psychologist. The last ten cards of the new series, because of their abstractive qualities, are more difficult for the subnormal individual to handle verbally. In addition, they do not seem to stir up her difficulties as do the more concrete presentations in the first ten cards. One quite disturbed Negro girl of 15, Doris, who gave rather meager but still rather balanced responses to the Rorschach Test, projected her problem into the first ten cards of the Murray pictures so freely and fluently that the examiner had trouble recording her stories. These stories centered around a parent who had only one child, a girl, or a boy. In one picture (new series—6BM) Doris describes a mother saying goodbye to her only son going to war: "The mother will be alone and all her thoughts will be about the boy. She will pray only for him and the Lord will keep him safe because he is her only child." In another picture (new series—3BM) a mother is crying because she can't find her only daughter. "She can't go on living without her daughter. Some people come and put the girl in an institution and the mother is crying so hard she can't figure out how to get the girl out." In card 14 (new series) Doris said, "There is a boy in jail and he's thinking how to get back to his mother. He did something wrong but his mother is all alone and he's gotta get to her." Story after story depicted this one theme, of separation of only child and parent. In investigating Doris' home situation it was found that her mother had rejected Doris in favor of two much younger children, two little boys on whom she lavished her devotion and attention. The mother felt Doris was like the good-for-nothing father who had deserted the home. When Doris began going out with "bad company" evenings and not returning until two or three in the morning, the mother felt

she could not keep her home. She told Doris she believed it would be a lesson to her to be locked up.

It not infrequently happens that subnormal girls respond to the Thematic Apperception Test in a brief matter-of-fact manner and do not seem to identify with any character portrayed. Consequently the test results fall flat as far as the examiner is concerned. Some other techniques may be more appealing to them or they may find it easier to do a task not requiring any direct story-telling. One girl interpreted each picture on the Thematic Test by a single word or short descriptive phrase as "one girl", "two dark men". This girl, Polly, had some talent for drawing and asked for pictures to copy. We found that she did not simply reproduce what she saw but added her own ideas in making her drawing. We also discovered that she wanted to tell us about these pictures of hers, in fact, she spontaneously told a story which included her wishes. For instance, we gave her a picture depicting a village green with surrounding houses. Polly added a large Christmas Tree in the middle of the village green, drawing and coloring a trimmed tree with gay ribbons and decorations. Polly said, "This is where I'd like to live. All the people are friendly here. You see they put up a Christmas tree and they bring presents and everyone in the family can have one. No mean people live there. That's my house. It is painted white and everyone says it's the neatest house in the village." This girl came from the tenement districts along the water front of a large city.

We have often given subnormal girls a task which we have called the House Test. On a sheet of typing paper on which a large rectangle is drawn we ask a girl to draw a plan of her house, how the rooms were arranged and where she and her family slept. After this task is done the girl is given a second similar sheet of paper and asked to make a plan for a house as she would like to have it, choosing with whom she would like to live and how the rooms are to be arranged. This technique often gives the examiner clues as to the problems a girl has brought with her to the institution. One girl,

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Edna, had run away from home twice when she was 16 years old. She was then placed in an institution for the feeble-minded. She told the Court that committed her to the institution that she was sure her step-father didn't like her, that was why she ran away. She seemed very surprised that he had cried when she was taken to Court. In the institution Edna never seemed to settle down. She was resentful, she was abusive to other girls particularly in the large dormitory where she slept. When she was given the House Test, which she seemed to take very seriously and with interest, Edna schematized the room and double bed where she had slept with her grandmother. In her "wish house" she had a room to herself and her grandmother was not included in the household, although her step-father was. In subsequent interviews it turned out that for many years Edna had slept with her grandmother who snored and took up most of the bed space. She ran away more to find a place she could call her own than for any other reason. Edna's great resentment toward the institution was that she had to sleep in a ward with forty other girls. She said, "I heard even in prison you can have a cell to yourself and cover the bed with a chintz spread and you can have your own Teddy Bear".

Just as aspirin or liver pills do not cure all physical ills, no one test procedure or projective technique reveals hidden attitudes of an individual. We often have to proceed by trial and error, supplementing interviews and observations of a girl's behavior with a variety of tasks and test procedures.

METHODS OF TREATMENT

"Diagnosing" the case and learning to understand the personality of the subnormal emotionally unstable girl is a much easier task than carrying out a course of treatment, guidance, education, and rehabilitating the individual to a more successful adjustment either in an institution or on her return to the community. We often know what to do about a girl but more likely than not we do not have sufficient resources at our disposal to do what we'd like. There is no real mother

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substitute for a girl who, rejected by her mother for years, persists in wanting only her own mother to take her back. Edna's desire was for a "cell" or a room for herself, but this she could not have in the large institution to which she was committed. In smaller well-staffed institutions programs to meet the individual needs of a particular girl can to some extent be worked out. In very large institutions which in war-time particularly are far from full-staffed, breaking into the institution routine program so as to give the individual what she might require by way of specialized recreation, guidance and therapy is far from an easy task. In the face of difficulties all we can do is to try some compromise procedures which may help the individual without dislocating the program for the whole institution community. After all, the emotionally disturbed girl upsets the institution routine anyway, so that any guidance she may get always gives institution authorities hope that the girl's nuisance value may be reduced.

As in methods of diagnosis so in guidance and treatment there is no one prescription for treatment nor any straight road to success. There are a few approaches to the task of handling and treating these unstable girls, however, that we feel have general application. These approaches we should like to discuss under the headings: a) General attitudes toward a girl, b) Work habits, c) Psychotherapy, d) Occupational therapy, e) Education and vocational training, f) Medical therapy, g) Recreation, h) Punishment.

A. *Climate*. What every institutionalized girl requires is to be treated with self-respect, especially by employees and staff members, and to be treated in a consistent manner, not to have promises broken or threatened punishments sometimes carried out, sometimes not. She also needs to be approached in an attitude of friendliness and genuine affection. Only under these conditions will a girl learn to adjust to institution life and be prepared for release to the community. However, any one having to handle the emotionally unstable girl, not just in a clinical situation, but in every day life, day in and day out, knows how nearly impossible it is to treat this girl

with self-respect and friendliness as well as to handle her in a consistent manner. Nevertheless, this should be the aim of attendants, matrons, teachers and all who deal with these girls directly—that is, if any semblance of rehabilitation is to take place.

B. *Work habits.* If the unstable girl is not markedly sick, physically and mentally, she should be given the opportunity to do regular work of some kind, commensurate with her ability as well as the needs of the institution. The fact that she has to get up at a certain time, do chores in the house, or go out to work even though for only part of the day, gives her a feeling that she is included in the regular business of the world and that she is not a privileged character who is free to do as she sees fit. It is very difficult to rehabilitate a girl who improves under therapeutic treatment but who has no adequate work habits toward some of the routine tasks that are essential to institution and community living.

C. *Psychotherapy.* Subnormal individuals usually respond to some form of psychotherapy. It is true that they may never succeed in gaining insight into the nature of their problems, nor do they seek psychiatric advice in order to have their difficulties unraveled. But they do obtain reassurance and a feeling that someone is interested in them if they have a chance to express themselves. Sometimes an unstable girl wants to speak with her doctor, sometimes with a psychologist or counselor. One very nervous and excitable girl had a little talk with a psychologist about her problems, how she knew she'd never get a chance to go home, how her mother never wanted the girl's own little daughter to know she had such a "queer" mother in an institution. After the talk, this girl, Mary, said, "Well, aren't I going to get a 'brain test' today?" When she was told she was not, she said, "Gee, what good news. I feel better already. Can I come up to talk to you next week?" The psychotherapeutic value of a conversation may be more effective if a counselor visits a girl periodically in her cottage or dormitory just to have a little chat. Unstable girls are so insecure they need to be reassured that they are doing better,

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that they still have a friend interested in them or one who will try to interest their families in them.

Sometimes these girls won't talk but they do seem to get relief and reassurance by writing or by drawing. One girl wrote what she called her "autobiography". She collected sentimental poems about home and mother which she pasted in a notebook. In the notebook she also wrote letters to her mother (which she never sent out since her mother was dead), saying how she realized one must do what a mother says for a mother can never be wrong. This girl was frequently shifted in her occupations in the institution as she found it so hard to apply herself to work for more than a brief period of time. On days she was particularly disturbed she could be quieted by being allowed to work on her "autobiography". In fact, giving her a new notebook and pencil made Ruby very happy and contented for quite a period of time. Another girl wrote monthly bulletins to three or four staff members, telling them of her progress and her set-backs and offering suggestions for the modification of her training and treatment. These bulletins seemed to offer the girl particular satisfaction. Another girl, Betty, who cleaned a staff member's room, discussed all her difficulties through the medium of notes which she left pinned to a doll the staff member kept on a chair in the room. These notes were usually purported to have been written by the doll to the staff member whom she called "Mother". The notes sometimes scolded the mother for not keeping her room neat, at other times there was great praise of the girl (Betty) who cleaned the room, telling how well Betty worked and how she never stole anything. As time wore on the notes changed to a review of the girl's own difficulties, her desires to run away, her inability to get along with a particular matron, and how she wished she could have a visit like other girls. The notes were always signed by "Susan", the doll, who explained that the girl had told her her troubles.

Subnormal individuals do not have as limited means of communication and self-expression as was once thought, provided they find a medium of expression possible and satisfac-

tory to them. Some girls enjoy painting and sketching, others prefer to act, even to act out their problems either directly or through the intermediary of puppets. One unstable girl was tried on a variety of techniques but she remained restless, preoccupied with sex matters, with feelings of self-abasement and hopeless frustration. One day, by chance, another girl remarked to her teacher that Lucy could play the piano better than Dolores who was just strumming. For nine years Lucy had not touched a piano but she remembered a waltz, a piece she called an "oversure" and a spring song. Arrangements were made for her to practice three times a week. This girl almost changed over night into a person with a purpose in life and with some animation in her face. The day after the other girls heard Lucy play they said "Good morning" to her for the first time in the two years she had been in a dress-making class. For the first time in nine years of a stormy institutionalized career, Lucy became a person in her own right.

D. *Occupational Therapy.* Occupational therapy is of course a form of psychotherapy, but one which perhaps needs particular mention since it has become so well established as a specialty, requiring teachers trained to do a good deal more than just teach handicraft skills. Learning skills of one kind or another not only develops the muscles of the handicapped but seems to help the emotionally unstable and the mentally ill to obtain satisfactions in actually carrying out a "creative" task. A great majority of emotionally unstable subnormal girls profit more from occupational therapy than from any other one form of activity. Sometimes it may take a long period of trial and error before a girl succeeds on a task and in making things that appeal to her. But once success has been achieved, these girls beg to go to occupational therapy class. Girls who are restless and unable to concentrate on schoolwork, or on regular jobs in a laundry or kitchen, will work for hours and with great patience in making a child's dress, weaving a rug, or embroidering a table cloth. It took Selma three years to do work that was quite skilled and that made her feel she was a success. She had been clumsy and

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a poor worker for a long period of time. When told one of her embroidered pieces would go to an exhibit outside the institution this girl worked with zeal and persistence—at a rate that astonished her instructor. In order to achieve success, however, the girl has to like her instructor. It is the instructor who plays the dominant role in getting the unstable girl to try her hand at some task and who encourages her to go on. The instructor, in fact, plays so important a part in the adequate adjustment of the unstable girl that this relationship must continually be taken into account in arranging a girl's program. As one girl said, "Don't think I'd be doing this job here if it wasn't for Mrs. E. I've got to help her out, see, prepare the work for some of the dopes around here. When it's done, I'll go back to my piece. I have my troubles (this girl had put her fist through a window and cut herself badly two weeks earlier because she got mad at someone) but Mrs. E. has hers too".

E. Education and vocational training. If an emotionally unstable girl is interested in and capable of fitting into a vocational or educational training program she should do so. Often after quite a long period in occupational therapy with supplementary psychotherapy of some kind, a girl is ready to join a group of more steady girls who are learning domestic arts or some needle trade. Some unstable girls do better if allowed to pursue a variety of classes, such as going to occupational therapy part of the time and to a regular cooking class the rest of the time. Others do better in working in a regular service of the institution or the laundry part of the time but attending occupational therapy also. For each unstable girl an individualized program has to be planned so as to meet her particular needs, as well as to keep her from being too much of a disturbing factor in any group. Other aspects of the girl's education need not be neglected, such as training in a simple academic subject. Often the subnormal girl is ashamed of her misspellings and her poor reading. She may rejoice in a chance to attend a remedial reading or English class, but she may run a mile if she feels she will be made to

appear foolish before the eyes of other girls. Since the unstable girl is characteristically insecure in many areas of her life experiences, she is likely to refer at some time to her lack of earlier school success. Sometimes, in this area, attending a small class in reading and spelling or having a little individual instruction will give her as much satisfaction and confidence as do other activities. One girl was willing to struggle with a primer when alone with a teacher but carried "Gone With the Wind" around with her as she moved about the institution. When she met the psychologist one day she showed her the book, remarking, "You see, I am reading now".

F. Medical therapy. Medical therapy is not within our province, but judging from successful expansion in this field in recent years it is necessary to mention this area of treatment. There are many times when only sedatives will help to quiet the unstable girl "on a tear". But if sedatives need to be given continually so that they gradually become ineffectual, and when psychotherapy in one form or another makes no headway, it seems time to look for some more basic way of reorienting the disturbed individual. For the more seriously mentally ill shock therapy is proving its worth. Sometimes the emotionally unstable girl does develop a psychosis so that transfer to a mental hospital is essential; but most of these girls remain at a severely psychoneurotic or pre-psychotic level. In some cases ambulatory insulin has helped considerably, provided psychotherapy and occupational therapy are carried on simultaneously. Endocrine therapy (thyroid) is being tried out in a small group of unstable girls who have periodic outbursts associated with the menstrual cycle. One girl, Frances, at the age of twenty, broke out into childish and manic behavior just prior to each menstruation. She jumped on chairs, knocked girls and attendants over, leaped out of windows. Between periods of excitement she was quiet but still quite playful, teasing less intelligent girls incessantly. After some time on thyroid therapy and attending occupational therapy this girl changed considerably. She now does all kinds of handwork. She is quiet and very friendly. She no longer takes delight in teasing other girls.

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Further expansion and experimentation in various forms of medical therapy will no doubt help in the rehabilitation of the emotionally unstable girl.

G. *Punishment.* The extent to which the emotionally unstable subnormal girl is responsible for the mischief she does and the obstinacy and disobedience she shows is a question that certainly cannot be easily answered. Is she less responsible than the girl who causes no trouble in the institution but who one day decides to steal some clothes and run away? She probably is less responsible, for her very insecurity and hypersensitiveness and impulsiveness seem to make her behavior more unpredictable. The unstable girl often does something "wrong" for no worthwhile reason. However, drawing any fine line between responsibility and irresponsibility can certainly not be done. Punishment is no doubt more convenient for the individuals dealing out the punishment than profitable to the one receiving it. Usually punishment is accepted as part of an institution set-up. For this reason the unstable girl cannot be treated too differently from the more stable girl. The form the punishment should take is the important point. It should certainly be constructive rather than destructive in its influence on a girl. She has to realize the institution has some authority over her, but the punishment should not be so severe or extended in its duration that an unstable girl loses the little security and ambition she has. Taking the girl for a short time out of work she likes best, (usually this is occupational therapy) or not allowing her to go to club meeting, or to the movies, on some occasions seem to be the most effective forms of restraint.

H. *Recreation.* One more approach in treating the unstable girl is that of recreation. She, like any girl or boy, needs recreation, a chance to play games, to join in club activities, or to do as she pleases for some time each day. But often she does not fit into the type of recreation available at a given time. She may refuse to play group games or to go skating. She may decide to turn the radio on very loud when other girls are resting. In fact, during recreation periods a seriously malad-

justed girl is likely to show her difficulties acutely. For this reason guidance has to continue for her during these times. But here, as in all her activities, as soon as the unstable girl gets some reassurance that someone accepts her, that she is able to do as others do (such as write a letter home, play ping pong, dance), she begins to make use of her leisure time in a manner more acceptable to those around her.

Obviously, a large volume could be filled with discussing ways and means of handling unstable girls, especially since the treatment often has to be individual. Just what can be done for the individual depends in large measure on the resources available in an institution, material resources as well as trained personnel. This problem of available resources leads us to our next section on the type of environment most suitable for unstable subnormal girls.

TYPES OF INSTITUTION

The type of institution to which a subnormal girl is committed depends on the resources of the community to which she belongs and on the type of problem she presents. If her subnormality and inadequacy are the outstanding features, she is most apt to go to a state school for defectives; if her asocial tendencies loom large in the picture, she is more likely to be committed as a delinquent. The unstable subnormal girl usually does less well in a reform school than in a school for defectives because in the former institution she has to compete with so many individuals more intelligent than herself. This competition is difficult for even the most placid subnormals: for the unstable it can be almost devastating. The unstable subnormal also does better in a small rather than in a large institution for defectives because in a small institution she has more chance for individualized care. Some unstable girls who became so upset in a large state school that they exploded to the point of overt aggressive acts, have quieted down considerably when placed in a small institution for defective delinquents. Here more time can be spent in studying their needs and in offering them a varied program of work and recreation. Some

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unstable girls, of course, develop such severe psychopathology that the only placement for them is transfer to a state hospital for the insane. The girl, Leona, whom we referred to earlier in this paper, accepted life in a large state hospital much better than in a state school. For some reason she felt better appreciated in the hospital. She wrote, "I like my work. I clean the attendant's home and no longer see dopes around me".

The majority of the unstable subnormal girls must remain in state schools, however, for their psychopathology is not severe enough to send them to state hospitals, nor are their delinquencies serious enough to commit them to institutions for defective delinquents. But in large state schools they are also misfits and the therapy they can receive has to be simple and circumscribed. Perhaps the wisest procedure would be to set up special units consisting of small cottages within a large state school, units providing psychiatric, medical and nursing care as well as medical therapy and psychotherapy (including occupational therapy), administered under specially trained attendants and teachers. After a more or less prolonged treatment period, these girls might be rehabilitated to fit into the regular groups in the school or to go directly out into the community on parole either in a colony belonging to the state school, to a private family as a working girl, or back to their own homes.

The unstable subnormal girl who spends most of the years of her life moving from one institution to another or entering and leaving an institution by the revolving door method can cost the taxpayer a large sum of money. It would seem that any amount of expense in establishing some sort of preventorium, such as a psychiatric unit in a state school, for adolescent and young adult girls who show marked emotional instability but who have not experienced years of failure and maladjustment in one institution or another, would be justified.

THE EXTRA-INSTITUTIONAL TREATMENT OF SEX OFFENDERS

LOWELL S. SELLING, M.D.

The legal tendency to lump all sex offenses into one category is markedly at variance with the psychiatric aspect of these offenses. The mental reaction of the offender who uses indecent language before women and children exhibits a different psychological process from the exhibitionist (indecent and obscene self-exposure) or the pedophile (molesting children), yet if we take sex offenders as a single group we will see that the treatment aspect of these offenses has changed greatly since the institution of clinics in criminal courts, most of which have been set up since 1930. With the increased use of the psychiatric examination and the sentence which involves psychiatric treatment, the attitudes of courts has changed towards leniency.

It is quite true that many sex offenses were ignored in the past. Indecent exposure, for instance, was not even reported to police departments until the latter part of the 19th century, but since 1900 and prior to 1930 a sex offense, no matter how trivial, was likely to result in a very harsh penal sentence.

It was early recognized that the sex offender was a medical problem. Sterilization and even castration were proposed as cures, but these suggestions, which were made largely by laymen or non-psychiatric medical men, failed to have wide acceptance because of the intense resistance of large segments of the population toward this type of operation. Studies of sterilized and castrated sex offenders, while still inconclusive, tend to indicate that operative measures are not the answer to the problem and that loss of sexual power through operation is likely to cause a more vicious reaction than it is to stop antisocial behavior.

During the fifteen years ending in 1945 little change has been noted in courts where there is no psychiatric service, but in the criminal courts of the large cities an increased number of sexual offenders have been referred to the clinics, and the recommendation of the psychiatric staff has been found by the judges concerned to be of marked value. Except for rape and a certain number of offenses concerning young children, sentence to corrective institutions has been allowed to fall into desuetude; but it is true that when psychiatric treatment has failed and the offender commits sex offenses repeatedly, incarceration is the only answer that society has to protect itself.

Contrary to the notion which has existed in the minds of most jurists up to the present time, most sex offenders are not chronic offenders, and studies from the Recorder's Court in Detroit indicate that such offenders are likely to be self-curing. Of the first three hundred sex offenders studied in the Detroit Clinic, only seven had a subsequent police record during a period of approximately twenty years since the arrest.

Sex offenders except in very rare instances—those in a fraction of 1% in the Recorder's Court group—do not change in the nature of their offenses. Exhibitionists, for instance, only committed the offense of molesting children twice in 842 cases. There is no record among 2,487 sex offenders of an exhibitionist or a molester of children committing rape, with the exception of one man who was found to be psychotic (insane).

Indecent exposure: The most frequent minor sex offense is indecent exposure. More than two-thirds of these cases are due to carelessness, indifference, or biological urge where the individual masturbates or urinates in an exposed place, perhaps believing himself to be concealed from the public eye. These offenders are mildly feeble-minded. The catastrophe of arrest, trial, and the clinic experience seems to teach these people that they must be more circumspect in their conduct. The true exhibitionist exposes his genitalia in order to excite in the female viewer a reaction of hostility, pleasure, or sexual excitement. The ego-satisfying results of this exposure are so

great that the exhibitionist repeats frequently before his arrest. Oftentimes he is able to arrange for an assignation by virtue of his exposure. Usually, however, his exposures are made to immature persons on whom the exposure would have a directly opposite effect.

Exhibitionists are usually found to have the belief that their potency is declining, frequently have guilt feelings due to masturbation and, in some instances, because their wives are frigid, they have a subconscious desire to revenge themselves on the whole of womankind. An occasional case is seen which follows this pattern in the unmarried, as for example in a case where a jilted man exposed himself on several occasions immediately after being "thrown over" by his girl; but after a night's sleep the exhibitionistic tendencies stop completely. In cases of indecent exposure the determination must be made whether therapy should be directed at guilt feelings or whether it can be planned to operate on a more superficial level. The therapy in the case of exhibitionism must be directed toward, first of all, the removal of the cause. If the causes are external situations, such as the attitude of the wife in case she might be frigid, ailing, or have an antagonistic personality to the patient, then the therapy might primarily lie in adjusting her attitude or even in separating the patient from her.

Exhibitionists in many instances are unmarried. An ideal arrangement, if it were socially possible, would be to give such men a normal sexual outlet with a sympathetic woman as a mate, and it may very well be that in some time to come specially trained prostitutes will be available for such therapy. At the present time a plan such as this would arouse intense antagonism of church and even civic authorities, but it is the answer to the problem of the unmarried or the badly maladjusted exhibitionist who feels that he is losing his sexual power.

Psychiatric treatment can be carried out either in court clinics or by private psychiatrists who will report to the court psychiatrist if there be one. Psychiatric treatment lies in: (a) the explanation of the nature of the deviation in an attempt to give the violator insight into his own mental pro-

cesses; (b) suggestive therapy indicating to the offender how serious the eventual results will be from a legal standpoint, particularly in those states where there is a law permitting the permanent incarceration of sexual deviates; (c) prophylaxis—it has been found practical in most states to devise a recreational plan which will take the exhibitionist out of his motor car if he has a tendency to expose himself in the car, or to take him from a neighborhood where he has a reputation of exposing himself, while at the same time an attempt is made to provide him with wholesome leisure time and activities, athletics, spectator sports, hobbies, clubs and other acceptable organized social activities.

Pedophilia: No crime is as revolting and socially unacceptable as the physical molestation of children, yet its mechanism is probably easier to detect. In practically all cases of molesting children it is found that the molester is impotent. In some instances he is a latent homosexual whose normal potency is aroused only by contacts with young boys. For the most part, he is a psychological deteriorate and one who has marked guilt feelings about his earlier sexual activities and masturbation which leads up to the feeling of impotence, even though he be quite normal. These cases act like conversion neurotic cases and are unable to give an account of the "why" of the conduct. In some instances they must be given considerable insight during a series of psychiatric interviews. The use of male hormones has proved to be beneficial in a large number of cases. Maximum doses of testosterone propionate and similar medication are given consistently. Whether it is due to the psychological effect of this drug or its actual organic value cannot be determined, but fairly chronic pedophiles tend to show more interest in normal sexual behavior after such treatment.

Homosexuality: There are two groups of homosexual individuals who are brought before courts. The first group are those who publicly accost police officers. These are usually confirmed homosexuals whose abnormality is deep seated. In these cases it is only possible to advise them to control their

behavior, either to remain as chaste as possible or, if they must consort with homosexuals, to deal only with those with whom they are acquainted. These old timers frequently have a coterie in some community to which they can turn and in that sense they can make an adjustment.

There is a second group of homosexuals who are arrested only by chance. They show some sexual immaturity and a lack of comprehension of sexual drives. Sometimes these boys are responsive to an officer's suggestion that they make a date merely because they are curious. In other instances they have been indoctrinated to some homosexuality and are almost bisexual in their attitudes. Psychiatric therapy in these cases has proved to be very useful, first in controlling the offender, and second in directing his sexual interests into heterosexual activities even though they may not be fully expressed. It is useful here also to aid the incipient homosexual person to make social contacts with girls and for the psychiatrist to be at his beck and call to advise him if there should be any problems in his heterosexual interests, desires, and feelings. Hasty marriages are to be condemned, but these persons often resolve their problems if they marry a properly sympathetic mate. Because they feel a partial tendency to homosexuality, they do have a tendency to try to correct it by indiscriminate marriage which, because of failure, may crystallize homosexual tendencies. Inexperienced probation officers often advise homosexual persons to marry to solve their problems; truly dangerous advice.

We might note here that female homosexuals are not serious legal problems unless they care to impose their will upon their lovers or to commit homicide when the object of their affections endeavors to dissolve the association. A manish woman can usually make an acceptable adjustment, for if she accosts it would be for prostitution in an attempt to dominate the male rather than for homosexual purposes. Prevention of serious crimes by female homosexuals is the problem of the private psychiatrist, who works to resolve thwarted love responses. It is too late for much therapy after a crime

of violence has been committed and the woman brought to Court.

Prostitution: Since sex is involved in prostitution it must be listed as a sex crime, but it is not primarily as much of a sex crime as it is a commercial problem. There are two serious dangers which the prostitute offers to a community; first, the spread of venereal disease, and second, the destruction of sexual capacity in the immature, inexperienced, or incompetent male. Because of the limited intelligence of so many prostitutes the Court Clinic sees a number of male sexual offenders who have become so because their egos have been trampled on by the prostitutes, manner. In most instances prostitutes come from an inferior social group. Their chronic prostitution is fixed by the fact that they can make a good income, that they have no narcissistic body pride, or that in some instances they may have a marked penis envy which lies behind their desire to control, dominate, and drain the male of his potency. Since so many prostitutes commit this offense because of the financial desirability of sexual promiscuity, the only competition that can be offered to get them out of prostitution is a better job. Since, unfortunately, so many of them are of inferior intelligence, they can not hold jobs which compare favorably with the financial inducements of prostitution, so that the situation, at the present time at least, is hopeless.

The psychiatrist in the court finds that there is little that can be offered in the way of direct therapy to cure prostitutes. However, the repeated arrests and fines to the point that the compensation declines can do more than any type of psychotherapy to deter prostitution. Of course, if the prostitution is due to nymphomania or to a psychiatric complex, the patient can be turned from this activity after having had some psychiatric help, for in such cases the remuneration is not the prime factor.

Other Crimes: Statutory and common-law rape, bigamy, and sexual murder are seen from time to time, but no set therapeutic procedure has been devised for these cases as they are relatively infrequent. Community attitudes usually demand

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that these persons be incarcerated. The opportunity for out-patient treatment, therefore, is very slight.

In conclusion we might point out that out-patient therapy of sexual offenders depends on careful diagnosis to determine the psychological mechanisms and motives, psychotherapy directed toward removal of these causes, and occasional use of endocrine glands as supportive therapy in sexually inadequate persons, even though the sexual inadequacy may exist on a psychological basis.

THE SEX OFFENDER IN CUSTODY

L. CLOVIS HIRNING, M.D.

No type of crime excites so much public interest as the so-called sex crime. The emotional participation of the community in this type of crime is an outstanding and significant feature. In the South it is usually a sex offense that sets off a lynching bee. In the North it takes but a few co-incidental cases to set off, with the ever ready help of the newspapers, a sex crime wave. The sex offender is regarded with great suspicion and hostility. The very emotional reactions of the community and of the authorities who are responsible and responsive to public opinion complicate, as we shall see, the problem of sex offenses and the handling of them. Without going into the causes of society's peculiar attitude toward manifestations of sex, both "normal" and "abnormal", it is not too hard to appreciate how each individual's repression of his private sex conflicts may color his conscious reactions to sex as a social phenomenon. He projects his repressive and suppressive reactions on manifestations of sex brought to his attention. An individual with an outstandingly intolerant attitude toward sex is probably sitting hard on his own sex volcano. Since so many of the mechanisms observable in sex offenders can be discerned in so-called normal people who have succeeded in coping with these mechanisms only by strong repression, it is not surprising that there should be such marked emotional reaction to sex offenses, with a projection of the repressive mechanisms in each member of the community on the offender.

This same type of reaction probably plays a role in society's attitude toward mental illness in general. Severe censorship of books, plays, and movies bear testimony to society's attitude on the subject. We wish to ban the devil by banning any public recognition of his existence. Again and again plays have been banned in a cosmopolitan city like New York be-

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cause homosexuality has been accorded some public recognition. Thus, as by some magic, we obliterate that which produces conflict in us. Part of the sex offender's offense is his irritating the old wound.

Fear of mental illness, as an unpredictable unknown, probably also plays a role in the community's reaction to sex offenses. There is some recognition that the sex offender may not be normal mentally.

A semantic analysis of the terminology used in connection with sex offenses and sex offenders is a very revealing procedure. We find that the terminology is replete with emotionally charged words, many of them having no real meaning. The word "degenerate" is an example. This word is an adjective or a verb. It is used in biology as an adjective to indicate anatomical or functional impairment genetically or somatically, or as a verb to indicate the process of such impairment. It has no meaning used as a noun. Its use as a noun is almost purely an emotional word. Yet not only is the word found in meaningless legal mumbo-jumbo, but in books on sex problems otherwise carefully written. Thus in a scientific and objective study of sex offenses, such as Doshay's book, *The Boy Sex Offender and His Later Career*, the word is used as a noun three times and is even indexed as such (although in one place it is referred to as careless usage). There are many more such examples written into the law itself, including such expressions as, "the crime against nature", which indicate the semantic meaninglessness but high emotional charge to which I am referring.

An adumbration of society's strong emotional reactions toward sex offenders is no introduction to an academic discussion of an interesting sociological phenomenon. It is integrally related to the problem of the handling of the sex offender. It is important to a discussion of the sex offender in custody to draw into relationship, on one hand, the existence of so-called sex crime waves, the handling of sex offenses by the organs of public expression, and of sex offenders by the authorities who are responsible and responsive to public

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feeling; and on the other hand, the difficulty in dealing with these problems psychiatrically in spite of the essential and obvious psychopathological nature of so many sex offenses. The difficulty arises from the reactive defensiveness of the sex offender himself to his own super-ego, reinforced by public censure. It is during the period when the sex offender is first in custody that he is most subject to the strong emotional reactions of the community, and he is buffeted also by the emotional reactions within himself and within his family. No one feels so forsaken as the offender who has run afoul of some of society's most deep-rooted taboos. Few offenders are more defensive. It is notorious that very few sex offenders admit guilt, except sometimes on advice of counsel they may plead guilty to a lesser charge in order to escape the more severe penalty of the original charge. This is true in felony cases. In misdemeanor cases, especially cases of indecent exposure and impairing morals, if an individual admits guilt, he usually denies the sexual implications of his act. He was either taking care of natural needs such as urinating, or he may claim that he was attempting a little sex education. This was the claim in a recent notorious case involving a teacher who pleaded guilty to a charge of indecent exposure, but claimed that his motives were of the best and were misunderstood.

It is interesting that the phenomenon of "crime wave" is an outstanding feature of sex offenses. It apparently takes only a few co-incidental widely publicized cases to make the nucleus of a sex crime wave and to arouse public feeling. On closer scrutiny, most of these so-called sex crime waves appear to be another manifestation of the strong emotional reaction within the community to sex, especially when it runs counter to established patterns. The compulsiveness of many sex offenders may cause them to respond to this strong emotional display with a reactivation of their own inner conflicts to produce some increase in the number of offenses. There is ample evidence that so-called sex crime waves are largely a matter of newspaper headlines, and that the concomitant sensationalism is mistaken to signify a crime wave. With the exception

of murders and bank robberies, sex crimes are the most head-lined. The tendency of the press to capitalize on the strong surge of emotion that runs through the community when there are a few co-incidental sex crimes readily gives the impression of a crime wave. The police respond to the pressure by going after sex offenders with renewed vigor. This situation seems to have been brought about in the Spring and Summer of 1937 in the region of New York City with the occurrence of three murders committed by sex offenders. Newspapers vied in reporting sex offenses. There were meetings and conferences of law enforcing authorities, as is usual in situations of this kind. During the period of excitement, many proposals were made, mostly of a coercive and punitive nature. Many harsh words were used and woe was the cry to the sex offender. In spite of all this, the number of sex offenses did not decrease. Indeed, minor sex offenses such as indecent exposure cases increased markedly.

Committees of prominent citizens were appointed in various communities in and around New York City. One such committee did a very creditable job of analyzing sex offenses committed in New York City during the ten year period between 1930 and 1939. The report of the Mayor's Committee for the Study of Sex Offenses after carefully examining the figures was that, "There was no wave of sex crime in New York City during the 1930's". There was noted, however, some increase in the number of sex crimes in the latter part of the 1930's, representing, in part, increased police activity. It is interesting that the only sex offenses that increased significantly to almost justify the term crime wave, were indecent exposure cases. In view of the public character of these cases in parks, etc., increased police activity might be expected to bring in more of such offenders, and it did. In 1936 there were 277 of them in New York City, and in 1937 there were 501. Another factor probably involved is the essentially compulsive character of this type of sexual behavior, and its activation by the strong surge of repressive emotion that goes through the community. This point will be discussed below.

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It is important to bear in mind the readiness with which coercive emotions are aroused in connection with sex offenses reflecting fear and hostility. The writer has seen timid, ineffectual exhibitionists treated like potential sex murderers by the police who apprehended them. Once even a probation officer apparently felt called upon to "take a swing at him". Again and again I have noted police treat such an individual roughly and apparently feel justified in so doing. A sort of righteous indignation covers and reenforces the hostile impulses somewhat as with lynch mobs, Nazi brutality to Jews, etc. The writer has seen an inoffensive, mincing transvestite brought into the hospital for observation doubly handcuffed, each hand to a burly policeman. He has talked with elderly men who have quaked in fear. One was terrified of being castrated because he had been told that the medical treatment for "degenerates" was such a procedure. Not so long ago *Time Magazine* reported a judge in California as giving a sex offender the choice between a very long prison term and castration. Here it is important to point out that castration has no part in the medical treatment of such individuals, and that it is, indeed, a very dangerous procedure for the mental health of the subject involved. It precludes the possibility of any subsequent psychotherapy and, most important of all, it tends to warp further any psychopathological tendencies an individual possesses. In the opinion of the author, it might turn a relatively mild case of pathological sexuality into a hopelessly embittered and maladjusted individual whose psychopathology might very well take on malignant aspects, leading him to become a potential menace and even encouraging his progression toward becoming the very much feared sex murderer. This is true particularly if the castration includes the amputation of the penis as well as the removal of the testicles. Simple removal of the testicles does not interfere with the ability to have sexual intercourse except, perhaps, psychologically. Yet, in either case, since feelings of impotency are so often a part of sexual psychopathology, the psychopathology is only aggravated by the procedure of castration. The handling of sex

offenders in custody is marked by strong emotional bias and ignorance. This situation has more than humanitarian significance; as will be pointed out later, it is prejudicial to psychiatric exploration and rehabilitative work. The writer has seen individuals deserted by relatives and friends, treated with poorly concealed contempt even by the lawyer assigned to their cases. Small wonder, then, that sex offenders of the misdemeanor (indecent exposure and impairing morals) class rarely plead guilty, but stoutly deny their culpability even after being convicted and sentenced. According to a report of the Mayor's Committee on Sex Offenses, 74% of individuals charged with a sex felony were convicted by being allowed to plead guilty to a misdemeanor. Of those charged with misdemeanors, very few admitted guilt unless allowed to plead guilty to a non-sexual charge such as disorderly conduct. In my own study of sixty cases of indecent exposure, only six admitted any sexual implication to their activities. Such a state of affairs militates against the delineation of a problem for psychiatric diagnosis or treatment.

Some education of police and other custodians of sex offenders awaiting trial, in the psychology of sex offenders and in the proper handling of them would help a great deal, not only in preparing them for psychiatric exploration, but by increasing the number of guilty pleas, an eventuality which should appeal to the law-enforcing authorities. Detectives connected with the Westchester County Parkway Police Department have taken courses on the personality of diagnosed sex offenders under the late Dr. Ira Wile. They claim they no longer treat such men like other criminals (or worse, as is so often the case), and find that the understanding approach is more successful for purposes of investigation.

Although it is manifestly impossible to give such a course within the scope of this article, it may be important to discuss the classification of sex offenses, and then to attempt some descriptive analysis of the personalities of individuals who may be guilty of the various sex offenses; not that any one of the sex crimes as listed in the law is the exclusive prov-

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ince of any one type of personality or psychopathology (although I doubt that any addict of indecent exposure would commit a forcible rape) We shall see that there is often quite a discrepancy between the nature of the offenders' sexual interests, pathological or otherwise, and the classification of his offense legally. This state of affairs is largely due to archaic and [irrational] provisions of the law which we shall discuss briefly.

There are several types of sex offenses, divided into two degrees of gravity: the sex felonies and sex misdemeanors. Interestingly enough, there are more felonies than there are misdemeanors. Some offenses such as carnal abuse are both felonies and misdemeanors, depending upon the age of the victim. Also, some sex offenses are not recognized as such in the law, but are prosecuted because of some special intolerance in the community or zeal on the part of law-enforcing officials, and are handled as "disorderly conduct" or "vagrancy". Transvestites are often handled in this manner.

The sex felonies in New York State are in order of gravity as indicated by maximum sentence: forcible rape, sodomy, statutory rape (age of consent in New York is eighteen), abduction, seduction, incest and carnal abuse. The chief sex misdemeanors are impairing the morals of a minor and indecent exposure. Also in the misdemeanor group fall many sex offenses not formally recognized as such by the law, but handled as "disorderly conduct", etc., such as voyeurism (Peeping Tom), various manifestations of fetishism such as hair-snipping and stealing of women's clothing, "molesting" women, transvestitism, male and female prostitution.

How are we to correlate sex offenses with sex offenders? The task is not easy because the offenses are not considered in terms of the specific offenders, but in terms of an archaic penal law which cuts across psychopathological lines. In most states the law does not consider even the age of the offender. (In New York State, Section 483-a of the Penal Law is exceptional, making tampering with the sexual organs of a child under ten by a person eighteen years of age or over

a felony.) However, statutory rape of a seventeen year old girl by a sixteen year old boy is also a felony. So-called "heavy petting" by adolescents could be classified as attempted statutory rape since the willingness of the girl or her relative state of sexual maturity are not considered in the statute at all. For example, in *People vs. Gibson*, 232 N. Y. 458 (1922), the Court stated: "With the age of consent fixed at eighteen it may not confidently be stated that all girls under that age do not comprehend what they are doing when they consent to intercourse. The law, however, deals with all and not with individuals. In law the act of intercourse. . . is without their consent and against their will. The state says that they do not consent or that their apparent consent shall be disregarded. It offers resistance for them. It deals with the case as rape, not as a mere statutory offense". The Mayor's Committee report calls this an excellent example of legal mumbo-jumbo.

With reference to the crime of statutory rape in New York, there are indications that the courts are attempting to rectify this example of legislative traditionalism. A large portion of so-called sex crime is of this variety. According to the Report of the Mayor's Committee, 59% of all sex offenders convicted in the Court of General Sessions and County Courts were charged with statutory rape. Of 1,948 defendants charged with this crime who were convicted, 80% were convicted of a misdemeanor, and of the 1,554 so convicted, 98% were convicted of assault in the third degree, a misdemeanor and an entirely different offense. It appears that 83% were under 31 years of age, and most of these were in the sixteen to twenty year group.

The crime of statutory rape gives us no clue as to the personality of the offender; in other words, almost anybody (except an individual with a pronounced sexual deviation such as homosexuality) could be guilty of statutory rape. Many of these cases are essentially a matter of promiscuity among young people. The young offender and the victim are often somewhat akin in age, and the victim is not always a

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victim except in a legal sense. Cases are not uncommon in which the victim was largely the instigator of the illicit relationship. On the other hand, often there is a youthful love relationship which comes to light with a girl's pregnancy. The present war situation has intensified this problem. One such girl of seventeen came to the writer's attention. Her lover, an eighteen year old boy, had just gone into the Army. She had not informed him of her plight. She said, "I just wanted to really belong to him before he left for war". The boy is technically guilty of statutory rape. Such cases are "sex offenders", only in a technical sense. Their offense gives no clue as to their personality except to emphasize their normality.

The amount of juggling of the charge that goes on in courts of law in connection with sex offenses is amazing, and is a further reflection of the archaic state of our laws. It further indicates in many cases an attempt on the part of the District Attorney and the court to adjust the crime to fit the individual, to make allowances for social, economic and psychological factors, and because it is not always easy to build up a case that will meet legal tests. Unfortunately, in New York State and in many other states, the probation officer can only make his pre-sentence investigation and report after the individual has made his plea and the charge juggling has been accomplished. In New York City they found that only 22% of the total of all sex offenders were convicted of the offenses charged in the indictment, or a lesser degree of the same felony.

How is the court to be guided in its evaluation of the individual offender in terms of his background and personality, the significance in his psychological make-up, of the sexual activity for which he was arrested, the potential dangers, the possibility of rehabilitation, and psychiatric orientation?

This can only be accomplished by a pre-pleading probation investigation and by early psychiatric examination.

To pursue further our discussion of correlation of sex offense and sex offender, let us consider the situation in forcible

rape, one of the most serious sex felonies in the law, carrying with it a maximum penalty of twenty years. This is largely a crime of youth. Eighty per cent of all offenders in cases of forcible rape from 1930 to 1939 in New York City were under thirty-one years of age. There was not one individual over sixty years of age. Although there is no specific personality type or sexual psychopathology peculiar to forcible rape, a large number of seriously psychopathic individuals are found in this category of offenders. Aggressive and sadistically inclined individuals as well as out and out sadists are among the rapists. However, as Havelock Ellis first pointed out, many cases of rape followed by murder are not committed by sadists, the murder often being committed to prevent discovery and escape apprehension.

Individuals convicted of rape appear to have a greater tendency toward criminal records of non-sexual crimes than do other sex offenders. In other words, the rape may often be incidental as a prologue or epilogue to another crime, such as robbery or burglary. In the New York City study, it was found that of 215 offenders with criminal records who were indicted for forcible rape, only 14% had records of arrests for prior sex crimes as against 86% with records of arrest for non-sexual crimes. This was outstanding compared with other sex offenders.

A fair number of psychotics become rapists; which is indicative of strong uninhibited sex drives often accompanying such psychotic states as manic-depressive manics, young schizophrenics, paretics and other organic cases. Any rape accompanied by senseless brutality, besides raising the question of sadism, should bring up the question of epilepsy and epileptic furor. One of the most notorious individuals in Westchester County, N. Y. was a man who raped and severely injured several women. He was an epileptic who was apparently thrown into a state of furor by sexual excitement. Any prolonged deep breathing was likely to set him off.

All cases of forcible rapists should be watched closely, as there is a strong statistical likelihood of their having crim-

inal records of some proportions, or of their being seriously psychopathic or psychotic.

Sodomy is a sex offense which is often characterized as "the crime against nature". It is punished severely with a maximum of twenty years in New York State, and even more severely elsewhere. The question of the use of force is not mentioned in the law. Rape of a male is a concept too foreign to our traditional thinking to have found its way into our laws, unless it be thought that the penalty for sodomy equalled only by the penalty for forcible rape is sufficiently severe to cover all cases. The prohibitions of the section of the law dealing with sodomy are rather heterogenous and somewhat vague. Here again the classification in the penal law cuts across psychopathological lines. Many kinds of individuals may be guilty of sodomy, but it is usually individuals who have profound inner conflicts regarding the opposite sex.

Relations between human beings and animals is prohibited. Intercourse with animals is said to be not too rare in rural communities. It is certainly not a frequent offense in more urban communities. These individuals represent rather extreme examples of sexual inhibition and timidity. The writer has had only two cases under direct observation, both cases had to do with sexual acts perpetrated with chickens. Both cases were men of the hired hand type, living very isolated lives with few social contacts and outlets. Fear of other human beings, coupled with a specific fear of women, seem to have played a role in their sexual orientation.

Also prohibited is intercourse by anus or mouth. In the latter case, both parties are considered guilty if the submission is a voluntary one. The acts of anal or oral intercourse are proscribed, whether the acts are between men and women or between members of the same sex. Other forms of parasexual practices are not mentioned. Due to the fact that either oral or anal intercourse is the usual *modus operandi* of homosexually inclined individuals, by far the largest number of individuals charged with this offense are homosexual. Particularly is anal intercourse the objective of the ancient and erst-

while even honorable practice of pederasty, which means specifically the finding of adolescent boys objects of sexual attraction and their use to satisfy the sexual appetites of older men.

In New York City the ten year study revealed that of 404 male victims of sex crime, only 35 or 8.6% were eighteen years of age or over. There is a considerable number of males of homosexual orientation whose sexual interest is fastened almost exclusively, if not exclusively, on immature individuals of the same sex. A certain number of these individuals find their way into various occupations involving close contact with youths such as teaching, Y. M. C. A. work, Boy Scout work, camp counseling, and even the ministry. They are frequently unmarried, taking little or no interest in the opposite sex. The most outstanding feature of the psychology of these individuals, as with so many individuals who seek immature sex objects, is that for them the mature female is tainted with their own unresolved sexual conflicts. There is a strong unresolved mother attachment (oedipus complex). To put it very simply, the mature female implies the mother who is a forbidden sex object, an interdiction reaching back into earliest childhood.

There is, in addition in these cases, a strong subconscious self-love (narcissism), the pederast seeking one who is as he would like to be, *i. e.*, a beautiful child. Frequently these individuals appear to be unable to rise above an adolescent level. It is at that time that every individual has to cross the oedipus hurdle into a successful heterosexual adjustment. In these persons, because of the strength of their fixations, the hurdle becomes almost insurmountable. The older an individual is, the more difficult it is for him to find expression for his interest in adolescents, and for this reason as well as other more obscure reasons such as his own guilt reactions, his sexual interests may become more and more an all pervasive preoccupation, coloring his social relations to a greater degree than when he was younger. These people offer no special problem in custody as do other types of homosexually orientated men, such as those who are attracted to, or offer attraction for,

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adult males with or without transvestism, to be discussed below.

Incest is a sex felony with a maximum penalty of ten years. It is, more often than not, an offense of older men involving father and daughter, although a fair number are younger offenders involving brother and sister. At first thought, one would think that this crime would be associated with a high degree of serious psychopathology and sexual maladjustment. However, observation and examination of some of these offenders does not bear this out. In spite of the strong social prohibitions and the incest taboo upon which psychoanalysis draws so heavily to explain sexual psychopathology, it is amazing not only how frequent the crime is, but the casualness with which it is regarded in some social groups, and how little it seems to interfere with an apparent good socio-economic adjustment of the individuals involved within their social level.

In many cases relatively little psychopathology is obvious, and such factors as propinquity resulting from over-crowded living conditions and adolescent sex curiosity seem to play an important role. The crime is most often found among poorer families, both economically and in social organization. Whether this is a real distinguishing feature, or only apparent because of the greater amount of social work done among these people, and their ignorance of contraception causing the crime to come to public attention more frequently, can not be said with certainty. Certainly, so many of these cases come to public attention only because of pregnancy that one wonders how much does occur without coming to public attention when there is no revealing pregnancy. It frequently comes to light that other members of the family knew of or suspected the relationship long before the pregnancy occurred, but said nothing until forced to by the interrogation of a suspicious social worker or probation investigator; and then they reveal what they know only with great reluctance. All these considerations suggest that the crime of incest is much more frequent than is revealed by statistics, and is not always associated

with as marked a degree of sexual or other psychopathology as we would suspect *a priori*.

The crimes of carnal abuse and impairing the morals of a minor will be considered together, because of their similarity insofar as the sex object is a child. Carnal abuse involves actual contact with the child's body in a directly sexual manner. The law in New York State makes an unusual distinction in connection with carnal abuse with reference to the age of the victim in determining the gravity of the offense and severity of the penalty. This type of distinction is all too infrequently made in the law, and carries with it intimations of making the penalty fit the criminal rather than merely the crime. As we shall see, the range of ages and personality constellations which are associated with sex offenses toward children is very wide. However, they have one characteristic in common: there is some fundamental organic or functional psychopathology which prevents the individual from seeking and finding sexual contact and satisfaction with mature individuals of either sex. Children are sexually relatively unsophisticated. They are relatively easily accessible and they are relatively sexually uncritical. This latter point is very important for some individuals who may be suffering from impotence or a feeling of sexual inferiority. Sex play with a child by a sexually immature individual is often not as threatening to him as the consequences of overtures to an adult man or woman would be. The sex offenders against children may be too timid or inhibited to deal with mature women or men on a sexual basis. Or, they may be mental defectives whose sexual approach is too blundering and distasteful to make any sexual outlet with a mature woman possible. The homosexually inclined individual who can not accept the full implications of his own sexuality, and who is full of homosexual conflict, may turn to young boys as a sexual outlet. He may even rationalize, if he is a teacher or camp counselor, etc., that the good he does for young boys may outweigh the harm he may do with his sexual advances. He may couch his sexual approaches in the guise of sex education, as one individual did who exhibited and

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demonstrated the manner of use of condoms to one of his charges.

Even though sex offenses against children are among the more serious from a social point of view, and considering the possible harm to victims in terms of psychological trauma, they are often the more hopeful ones from a standpoint of psychotherapy with the exception of the older offenders. Of course, the senile and arteriosclerotic ones are, as we shall discuss below, psychotherapeutically quite hopeless. In younger individuals the outlook is not too bad if, as is so rarely the case, the individual can have the benefit of really intensive psychotherapy. Indeed, as Clifford Allen in *The Sexual Perversions and Abnormalities* points out, it is not unusual when patients are being treated for homosexuality or impotence for them to pass through a stage of infanto-sexuality (the sexual object being of the opposite sex) as they slowly become adequately heterosexual. This, no doubt, shows the slackening of the bonds of the so-called oedipus complex and a release of attachment to the mother.

It follows that young sex offenders against children in particular should have the benefit of a psychiatric evaluation and the possibility of psychotherapy when possible.

The expression "degenerate", when it is not used for homosexually inclined individuals, is most often used in connection with individuals whose sex interest is toward children. A review of some of the types of individuals who are found guilty of such offenses will reveal how meaningless the expression is, and how much it is merely an expression of extreme social disapproval.

In the first place, we find the age range of offenders runs the entire gamut from individuals who are but little older than their victims to those whose age suggests senile and arteriosclerotic changes. It is with this latter group that intimations of degenerative changes are most appropriate, but in an entirely different way from what the loose emotional use of the term suggests. It is well known that degenerative arteriosclerotic and senile alterations cause organic variations in

the brain and produce varying degrees of personality change. Because of the scattered and patchy death of groups of nerve cells secondary to deficient blood supply to that portion of the brain in arteriosclerotic cases, and secondary to obscure metabolic changes in senile cases, there may be profound alterations in the individuals' intellectual capacity and emotional reaction patterns. Individuals may show deterioration of judgment and emotional instability. Mild and merry individuals may develop agitated and depressed states. Stolid individuals may become very emotional and irascible. Individuals with life-long puritanical sex attitudes may become earthy and even lascivious. Sexually inhibited individuals may become lecherous. The limitations of the possibilities of these individuals for sexual outlets may further channelize their sex interests in the only sex objects available to them—children. An added factor is the lack of sexual obligation which a sexually impaired or impotent old man may feel toward a child as against an older woman. Children are not defensive sexually, neither are they demanding or critical. In many ways children constitute a "safe" sex object for the old man to whom other sexual outlets are closed. In many individuals, life-long sex patterns themselves break down and the individual's sex interest is patchy and obliquely directed without any consciousness of sexual urge. The important point is that the sexual proclivities of old men may be the result of organic brain changes. However, these degenerative changes are no different qualitatively or quantitatively from the degenerate changes in the brain that occur in the favorite old aunt in the family or the most benignly childish grandmother who confuses her children with her grandchildren, who plays with dolls, and who hardly distinguishes night from day.

The writer remembers the case of a distinguished old gentleman of 79 who was caught in some sex play with children. The man had been a bachelor all his life, had lived with a sister, and had shown no interest in sex as long as she could remember. In his last years he became quite a problem

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because of his sexual proclivities. It was in a way fortunate that he died of arteriosclerotic complications soon after his arrest.

Violent crimes are rare with the elderly offender. In the New York City study none were indicted for forcible rape or abduction. The majority were implicated in the two crimes against children, carnal abuse and impairing the morals of a minor. The senile offender is the one above all who, both for his own benefit and community protection, requires custodial care of a more permanent nature. He should be treated as any arteriosclerotic or senile psychotic who needs custodial supervision because he can no longer care for himself. The mild supervision of an old folks' home where contact with children is at a minimum may be adequate in some cases.

Sex offenders of the indecent exposure type have been of particular interest to the writer. He has studied some sixty cases more or less intensively. They are frequently misunderstood and handled with a severity out of all proportion to their offense or potential danger to the community. As we shall discuss below, this very severity prejudices any psychiatric approach to the individual's problem. The indecent exposure is mostly not nakedness but quite specifically and almost invariably the exposing or demonstrating of the male sex organ to a passer-by, usually to a woman, sometimes to children of either or both sexes. Sometimes the demonstration in question is accompanied by suggestive gestures: sometimes the individual goes through masturbatory activity. The incident usually occurs in some secluded spot such as a park. The complainant, when it is an adult woman, is usually accommodately horrified and later expresses great disgust and indignation. So great is the feeling aroused and displayed that psychiatrists and social workers investigating the case often find it almost impossible to discuss the situation with the complainant.

The police and courts tend to handle these cases with considerable severity. The offender is regarded with great resentment and suspicion. The handling of the individual implies a feeling that he is a potential menace, probably a poten-

tial sex murderer. This is far from true. Most of the men arrested for indecent exposure, and there are many in the sixteen to twenty-five group, are timid, inhibited individuals more so than the individual whose sexual conflicts lead them to indulge in sex play with children. These individuals are usually too timid to do anything as active as that. They appear to come from rigid and puritanical homes, frequently incorporating the very proper and over-nice sex attitudes of their parents into their own attitudes toward sex and toward their own sexuality. They tend to be shy and timid, and to show little evidence of aggressiveness. Rarely, and except in a few senile and arteriosclerotic cases, do they have a record of any other offense except indecent exposure. They show evidence of rather strong superego (conscience) formation with the indecent exposure assuming the aspects of compulsive behavior. Their description of their proclivities is reminiscent of the masturbatory activity of the adolescent. This explains in part why, when sex crime becomes a newspaper sensation with much public emotion aroused, this type of offense increases in frequency, almost as the adolescent who has been warned against masturbation will struggle with the impulse all the more, only to relieve his accumulated tension by yielding. The history of such of these cases as will admit the sexual implications of their acts bears out the close relationship to masturbation. In one case of a seventeen year old school boy who demonstrated his penis to a six year old girl, analysis revealed that his need to demonstrate his penis was related to a castration anxiety engendered by over-severe handling of childhood masturbation by his parents. The boy had great conflicts over masturbation on one hand and, on the other hand, apparently sought to reassure himself as to the intactness and adequacy of his penis by demonstrating it. His timidity was further shown in the selection of a six year old girl as an audience.

Statistically, and by a study of individual cases, the writer is satisfied that young indecent exposure offenders are shy and timid, and almost incapable of more aggressive sex crimes.

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In some cases the indecent exposure amounts to a blundering and completely ineffectual sexual approach.

These cases would form a hopeful group to work with psychotherapeutically if their defensiveness did not preclude even getting started with them. Probably no sex offenders are more reluctant to admit their guilt than these—even after they have been found guilty and sentenced, and even though their offense is one of the least serious of all the sex offenses. In most cases there is a stout and persistent protestation of innocence and a rejection of any intimation that there is any problem in the sexual area. The individual in question often protests that he was surprised while urinating, and since incidents of indecent exposure frequently take place in secluded spots, there may be an element of plausibility to his story; and he sticks to it as a sort of face-saving device. The point is that in the vast majority of these cases (54 out of 60 studied) the individual in question denies his guilt vehemently and maintains such a stout and plausible defense that psychotherapy is all but precluded. This great defensiveness of the offender is a consequence of his own attitude toward sex, strong community attitudes against him, and over-severe handling of him by police and Courts. The combination of all three produces an all but impossible psychotherapeutic situation.

Another group of sex offenders who are dealt with over severely by police and Courts are the transvestites. While many of them are overt homosexual individuals, often male prostitutes, a fair proportion (exact figures are not available) are neither overtly homosexual nor involved in the social problem of male prostitution. The writer knows of one case of an artist, who is married and has two children, who did his best work secluded in his attic studio dressed in women's clothes. He rarely appeared in public in female clothing, and never engaged in any homosexual activity. He is a gentle, mild-mannered individual who has fortunately never been picked up by the police. Other similar cases are not so fortunate and have been dealt with by arresting police with undue severity. There was the case of a twenty-nine year old

colored transvestite who was picked up in women's clothes. He was handled with unusual severity by the local police and finally sentenced to one year in the penitentiary "for vagrancy" even though he had a job and possessed a good work record. This sentence to one year was much to the chagrin of the penitentiary authorities, who soon found that they had a problem on their hands. The individual's behavior was so feminine that he received considerable attention from other inmates. He was finally and reluctantly placed in solitary confinement for his own protection and for the morale (and morals) of the other inmates, where he remained for about five months. By that time the man was so upset that transfer to the Psychiatric Institute of Grasslands Hospital was necessary. He was detained at the Psychiatric Institute for the remainder of his sentence. There it was possible to adjust his daily life on a more normal basis. He was allowed to go to Occupational Therapy with the women patients, with whom he got along very well. He crocheted and sewed and was very happy. The writer had an opportunity to work with him more intensively and, on this man's discharge, he was much improved in his attitude toward his problem and toward society, although his fundamental personality was unchanged. It is obvious that police severity is of no constructive value whatsoever in these cases.

The writer is aware that it has been held by some psychiatrists that "stimulation of the latent forces of shame and guilt" by court procedure and coercive measures is of beneficial effect. Doshay (*The Boy Sex Offender and His Later Career*) is of this opinion in connection with boy sex offenders. He holds that the lack of recidivism of boy sex offenders who go through court procedure proves that the court experience is good for them. It should be pointed out that the court procedure referred to in Doshay's book is understanding and sympathetic, in contrast to the court procedure to which older offenders are subjected. The writer's opinion is that the prognosis in boy sex offenders is sufficiently good that even court handling of the offenders will not affect it. The amount

of sex experimentation that goes on in childhood, including adolescence, which fortunately never reaches the proportions of "offense" and court procedure, is much greater than adults realize. Only by careful and intensive work with "normal" adolescents (*viz.* in whom sex is not a part of the presenting problem) and adults can one appreciate the amount of childhood sexual curiosity that is satisfied by experimentation and play. The handling of this experimentation and play by adults can be very harmful to the child's psychosexual development—more harmful, in the writer's opinion, than some of the "sex offenses" of youthful offenders by and of themselves. In many cultures sex play among children is regarded with tolerance and even indulgence by their elders. Our culture is particularly rigid in this respect, even though it is a very common clandestine phenomenon, particularly in prepubescent and pubescent children. The great frequency of sexual experimentation in childhood is still not a generally recognized or admitted fact. However, it is not so many years ago that masturbation was considered a heinous offense and few would admit to having indulged in the practice. Now that we recognize that the practice is very frequent in childhood and an almost unvariable concomitant of puberty, people are beginning to admit to it. The writer has reason to believe that sex play and sex experimentation are almost as widespread in childhood as is masturbation. The time may not be far off when this fact will be recognized, as it has been in the case of masturbation. Sometimes it appears that the great to-do that is made of the sex play on the part of the youthful "offender" may be more harmful to his victim than his behavior may have been. Informal handling of the situation by enlightened and informed parents may be more desirable than the bringing in of police authority, going over the details of the offense, magnifying it out of all proportion and creating a court record.

Even in older sex offenders with more fixed patterns, severity and "stimulation of latent forces of shame and guilt" will hardly clear up the psychopathology underlying the of-

fense. This is so especially where "shame and guilt" have played an important role in the origin and development of the psychopathology, and in the setting of the sex offense. As we have seen, this type of psychopathology often plays a role in offenses against children and in indecent exposure cases. On the other hand, the report of the New York City study shows that, in general, sex felonies are not committed by recidivists, although a distinction is made between so-called normal and so-called abnormal offenders who tend to be repeaters. To determine whether the sex crime is a product of a so-called normal individual or an individual with an identifiable psychopathological personality make-up, is a task for a psychiatric examination. As we have seen, we seldom can tell by the crime itself which is which. There is no question but that detection and apprehension and conviction of offenders plays an important role, not only in reducing the amount of sex crime by removing offenders from circulation, but also in deterring some individuals whose sex crime is not a product of strong psychopathological sex drives—the so-called normal offenders.

However, the detection, apprehension, and taking into custody of sex offenders should not interfere with a psychiatric study and subsequent psychiatric handling of the case. The handling of sex offenders often produces an undesirable reaction in the offender by putting him in a defensive state. The sex offender should be brought under psychiatric observation promptly, as soon after he is taken into custody as possible, and with a minimum contact with the police. When possible, and especially in cases involving offenses against children and indecent exposure cases, the offender should be committed for psychiatric observation on a health officer's order, as a person whose actions suggest that he is mentally ill and in need of psychiatric observation and examination. Such procedure may require legislative action to include certain sex offenses as indication for psychiatric observation for mental illness. It would also require the facility of a psychopathic hospital or a psychiatric observation ward in a general hospital

in which an offender could be held, rather than having him spend weeks in a county jail awaiting trial. The sooner the individual is brought into the neutral environment of a psychopathic hospital, the more easily he is diagnosed and evaluated. He is less frightened and less wary. He may be expected to be more cooperative in discussing his problems, if he is not too obviously made to feel that he is a criminal, but rather a sick man with a problem needing help. Certainly his being thrown into a maximum security jail is not conducive to such a state of mind. If the individual is not psychotic or feeble-minded and demands his release by threat of a writ of habeas corpus, he may be taken before the local magistrate and committed on his order for observation and report.

The police authorities and local judges should be given instructions in the nature of sex offenses and something of the psychopathology of sex offenders as was done for the Westchester County Parkway Police by the late Ira Wile. Such instruction would serve a double purpose of insuring more intelligent management of the investigation and prosecution of the cases, and of a more understanding handling of the offender himself. The former consideration would lead to more detections and convictions; the latter would lead to putting the offender in a better state of mind for psychiatric examination and possible subsequent treatment.

There should be a pre-pleading probationary investigation with the consent of the accused, and psychiatric observation and examination with his consent if obtainable, and without his consent if the law will permit it as indicated above. These procedures would screen out the mentally sick, the mentally defective, and would reveal the more serious offender in terms of past record, personality make-up, psychopathology, prognosis, and potential danger to the community. Such individuals would not be allowed to plead guilty to a lesser offense than the one charged.

Publicity in these cases should be carefully controlled to prevent the newspapers from capitalizing on the sensational aspects of the case to the detriment of the offender and his

chances of being rehabilitated. This is especially important in smaller communities. If we talk of rehabilitation, then at least we should give such individuals as are rehabilitable every chance to restore themselves in their own self respect and in the regard of their fellow citizens. The writer has seen several cases where the question of rehabilitation hung largely on the publicity aspects of the situation. The less publicity, the better, if we are to have any hope of carrying out a program of rehabilitation. Publicity will not deter the non-deterable, but may prevent the rehabilitation of the rehabilitable.

PRISON MEDICINE AS A SPECIALTY

E. C. RINCK, M.D.

Prison medicine is a term applied to the practice of medicine and its allied branches in a prison or correctional institution.

The single, most important prerequisite of the successful practitioner of prison medicine is that he be a well adjusted, stable personality. Many of the situations arising in day by day contact with prison inmates are often quite trying and can only be met by a physician who has tolerance and patience. A large percentage of inmates who seek medical attention at the prison hospital do so because of personality problems, and not because of organic illness. It naturally follows that inmates from this group often represent the poorer strata of the prison population and include the frequent disciplinary violator, the homosexual, as well as the chronic "ne'er do well". Consequently, the prison physician, particularly if he does not have a speaking acquaintance with prison psychiatry, is inclined to become disgusted and think that his services might be of more value in other fields.

The successful prison physician must early recognize that men sent to prison represent personality disorders, and that the prison medical service has a tremendous responsibility in attempting to find the reason for the prisoner's previous antisocial behavior.

The prison medical department will be varied in size, dependent upon such factors as size of the institution, availability of funds, and the concept of what task the medical department is to perform.

A modern prison medical service should be organized along lines similar to any civilian hospital, with the exception that the psychiatric service, either absent from the civilian

hospital or present only as a consultation service, should necessarily be an active functioning service in the prison hospital.

However, necessarily, because of financial limitations, the prison hospital organization will differ from its civilian counterpart in the utilization of inmates for the performance of many sub-professional tasks. In ordinary prison hospital practice, it has been found entirely satisfactory to have only a skeleton force of civilian sub-professional personnel, directing activities of trained inmate assistants. Civilian nurses can satisfactorily train prison inmates to do most nursing duties. Similarly, prison inmates can be trained to be X-ray technicians, laboratory workers, pharmacy workers, etc.

The Prison Medical Service should have numerically sufficient physicians with the proper professional training so that the organization, hereafter described, can be adequately administered.

Organization of the Prison Hospital:

Professional:

- Chief Medical Officer
- Medical Service
- Surgical Service
- Neuropsychiatric Service
- Eye, Ear, Nose, and Throat Service
- Genito-urinary Service
- Psychological Service
- Dental Service

Sub-Professional:

- Nursing Service
- Laboratory Service
- X-Ray Service
- Pharmacy
- Physio-therapy

The duties and responsibilities of each service, as well as those problems peculiar to prison work, will be described.

Chief Medical Officer: This officer has the responsibility for the proper administration of the prison hospital. It

is he who must determine policy. His is the responsibility to see that funds entrusted to him are properly expended for the greatest good of the greatest number of inmates. He must interpret medical diagnoses and treatment to his colleagues of the Prison Administration. He must see that a proper standard of medical practice is maintained, both in the in-patient and out-patient hospital departments. If it is the policy of the Prison Administration to grant clemency releases to prison inmates suffering from incurable maladies, or to release dying inmates in order that their families not be stigmatized, then the Chief Medical Officer should always be particularly alert to see that this policy is carried out.

Paper work connected with the treatment of patients, reports as to their condition, reports to Parole Boards, etc., is as distasteful in prison as out of prison, but it is equally as important. Only by the eternal vigilance on the part of the Chief Medical officer, can good records be maintained.

Medical Service: This service is probably about the most trying of any of the prison hospital. Here are seen many individuals suffering from functional complaints, as well as the outright malingerers, etc. However, the Medical Service, properly administered, can be a very interesting and satisfying assignment. It is important that all patients be seen early, and proper therapy instituted. A proper hospital atmosphere must be established and maintained, in order to discourage the residence of those inmates who merely wish the "rest cure", or who are anxious to dodge some disagreeable assignment.

A certain percentage of prison inmates (generally greater than in civilian hospitals) complain of stomach distress, indigestion, etc. Many of these complaints appear justified, considering the fact that the institutional diet must provide adequate calories for the inmate doing arduous work, as well as the inmate desk worker.

Again, undoubtedly many inmates are tense and disturbed because of situations beyond their control, as infidelity of the wife, financial problems, detainers possibly requiring further imprisonment, etc. It is only natural that many inmates mis-

take symptoms of indigestion for organic disease, and appear on the medical service for study. It is also common to find a certain number of inmates who complain of stomach disorders only for the purpose of being placed on special diets. It has been the writer's observation that inmates naturally rebel against having to be just one of the group, and that they are continually seeking something a little different. As an illustration, when the majority of prisoners are housed in cells, space in the dormitory is always at a premium. If the situation is reversed, then cell block quarters are greatly in demand.

Special precautions must be taken in prescribing sedative drugs, as many prison inmates lack insight as to the causes of insomnia, and are prone to become habitual users of these drugs unless care is exercised in prescribing.

Surgical Service: The incidence of disorders amenable to surgery appear to be fairly common in prison inmates. Many men become prison inmates because of disabilities which impose a handicap in seeking employment yielding adequate salaries for living. They turn to crime in order to supplement a small income from legal employment. A definite service is rendered to the disabled inmate when the disability is corrected so that legal employment can be sought after prison release.

Inmates occasionally seek surgery for the correction of facial disfigurements, or even in some cases removal of incriminating tattoos, in order that their apprehension may be made more difficult following release from prison and resumption of illegal activities. Before corrective or plastic surgery is performed, the matter should be referred to the Classification Committee or a similar institutional body for approval.

Prison surgery should be conservative. Ordinarily, cases not considered as good surgical risks should be discouraged seeking an operation. Prisoners as well as laymen in outside communities rate hospitals on the quality of surgery performed. If the prison surgeon's operative mortality is ap-

preciable, or his results poor, the prison inmates lose respect for the prison hospital and its staff.

Neuropsychiatric Service: Because of the high incidence of personality disorders among prisons inmates, this is a very important service in the prison hospital. In addition, if the modern penal institution rightfully assumes the status of a treatment center, the psychiatrist will have to bear the burden of determining why the inmate violated society's laws and of prescribing the necessary treatment aimed at preventing future antisocial acts.

At present, psychiatric techniques for diagnosis and treatment are so time-consuming that only the surface of the problem can be touched. Helpful techniques such as hypnoanalysis and narcoanalysis have already contributed much to the difficulty, but a whole host of problems await solution. Rapport is difficult to obtain with the members of the prison population, if not impossible with certain elements as represented in that group of the constitutional psychopathic inferior states.

Treatment by the psychiatrist must be limited to a select few, or else the services of the prison psychiatrist must be spread so thin as to be virtually valueless. Group psychotherapy has been suggested as a means for treating a large group of offenders, but lack of homogeneity of prison groups as well as many other problems mitigate against its success. However, judging from our present knowledge, it would appear that this technique, if properly developed and cases properly selected, gives the greatest promise of solving the problem.

The prison psychiatrist, because of the nature of his work, will find all types of personalities seeking his attention, either for ethical or ulterior motives. Consequently, it is incumbent upon the prison psychiatrist to know well as many members of the prison body as possible. He should circulate about as much as his regular duties will permit in order to keep abreast of the daily gossip as it affects men who seek his services. In this way, he will be better able to evaluate the stories his patients bring to him for solution. It cannot be emphasized too much that the prison psychiatrist cannot function in a vacuum. He

should become acquainted with all aspects of the prison world as they affect the daily lives of his charges. He should visit the various shops, the living quarters, athletic events, and in short every portion of the prison schedule which bears upon the daily life of the prison inmate. Only in such a way can the prison psychiatrist really know the subject of his study and treatment program.

Eye, Ear, Nose, and Throat Service: As in civilian practice, the services of this specialty are much sought after in the prison hospital.

Many prison inmates with moderate to severe degree defective vision, will be discovered at time of primary examination to be in need of glasses. Similarly, it will be discovered that many inmates with chronically infected tonsils have never had either the time or the funds for tonsillectomy.

Genito-urinary Service: This service is of special importance in prison medicine because of the relatively high incidence of venereal disease among prison inmates. It is also of importance to the morale of the prison body that diseases which are potentially infectious to others be rendered non-infectious.

A unique opportunity to evaluate the results of anti-syphilitic treatment is afforded to the prison system, as it is one situation where regular attendance at the clinic can be insisted upon, and in some instances, long time observation permitted.

Lumbar punctures for diagnostic purposes should be done routinely in all cases of syphilis. A certain percentage of inmates object to this procedure, and consequently, it is good policy to insist upon permission when an inmate is being considered for the more responsible or more desirable institutional assignments. Because of the insidious nature of the onset of paresis, the prison physician who endorses the application of an inmate with syphilis for minimum custody or trusteeship without having a lumbar puncture made is treading on dangerous ground.

Psychological Service: This service usually is closely correlated with the neuropsychiatric service, and has the two-fold

responsibility of administering and interpreting the various psychometric and aptitude tests, as well as counselling inmates with personality problems.

Dental Service: Prison dentistry is limited in its task solely by number of personnel and funds made available for the purchase of supplies. As dental disease is the most prevalent pathology present in the inmate population, the prison dentist has a tremendous task when he attempts to correct all cases. It is first necessary to determine dental policy as predicated on funds and personnel available. Once this is done, no exceptions to policy should be made, as to do so necessitates extension of the excepted service to all members of the inmate body.

Considerable economy of funds can be effected in the Dental Clinic by utilizing services of trained inmates in the Dental Laboratory and for Dental hygiene or prophylaxis.

Nursing Service in prison can be satisfactorily performed by utilizing a skeleton staff of civilian registered nurses aided by trained inmates.

Prison inmates are trained by working on the job with experienced inmate attendants. Such on-the-job training should be supplemented by a formal lecture course given by one of the civilian nurses, aided by physicians. This course can be scheduled for some part of the day when ward work is slack. It has been found that it is best to outline the course, the lectures supplementing and accentuating points of importance. Such books as *The Hospital Corpsman's Handbook* provide valuable auxiliary reading and stimulate the interest of the inmate hospital attendant. Motion pictures dealing with hospital procedures are valuable and always well received.

There has been considerable argument over the merits of utilizing the services of male or female civilian nurses in prison. Much can be said for either point of view, though the writer is inclined to favor the employment of female nurses. Women in the prison hospital seem to make for a feminine influence which the sick prisoner appreciates. Also, women are by tradition much better housekeepers than men, and the pris-

on hospital supervised by a female nurse is usually much cleaner and neater in appearance than that supervised by a male nurse.

The advocates of male nurses in prison hospitals warn of the dangers to women in placing them in the midst of sex-starved prison inmates. This argument does not appear to have any merit when viewed in the light of experience.

The Laboratory Service should provide facilities for the examination of blood, urine, gastric contents, feces, etc. The more difficult technical procedures such as some of the blood chemistry procedures, serology, agglutination tests, and tissue work should ordinarily be sent to other laboratories.

Inmates can be trained to do very creditable and reliable laboratory work. However, before undertaking to train an inmate in this field, he should be carefully scrutinized as to education, intelligence, etc., as such training ordinarily requires at least six months.

X-ray Service: Ordinarily, the work of an X-ray technician can be entrusted to a trained inmate working under the supervision of either the prison physician or sub-professional civilian personnel. Because X-ray work is highly technical and the materials used quite expensive, care should be taken in training only inmates with the proper educational background.

The dangers inherent to X-ray work from exposure to X-rays or to wires carrying high voltages must be explained to the attendant.

Pharmacy Service: Here also the services of an institutionally-trained inmate can be utilized. Because of the large number of preparations dispensed, economy must be continually emphasized. The great bulk of preparations dispensed should be manufactured in the prison pharmacy unless they can be purchased more cheaply on the open market. Cough mixtures, milk of magnesia, throat gargles, and various ointments should always be manufactured in the prison pharmacy.

Certain dangers must be borne in mind in connection with the dispensing of prescriptions. In general, it is unwise to dis-

pense pharmaceutical preparations containing more than 5% alcohol, as to do so simply invites consumption of the preparation for its alcoholic contents. A good rule is never to dispense a preparation which if consumed at one draught might be poisonous or cause death. Inmates seem to have little respect for stated dosages.

Dangerous poisons ordinarily used for cold sterilization should be carefully watched and certainly never dispensed in a prescription. A few tablets of bichloride of mercury or mercury cyanide placed in a batch of food by an unrecognized psychotic would certainly endanger the lives of prisoners or participants of the officers' mess.

Narcotics as well as sedative drugs should be dispensed only by civilian personnel, who should satisfy themselves that the preparation has been swallowed if it is an oral one. A very careful daily accounting of drugs of this class is essential in order to avoid abuses or indiscriminate prescribing. There appears to be little justification for permitting the trafficking in sedative drugs said to be prevalent in certain penal institutions. If an inmate not hospitalized requires occasional sedation for sleep, the preparation should be dispensed and consumed in the presence of trusted personnel.

Certain drugs such as aspirin are reputedly much sought after by the more irresponsible elements in the prison population because of a "kick" derived from smoking the powdered drug. The writer is personally dubious that such a phenomenon does occur. Recently, benzedrine sulphate has appeared on the list of drugs highly sought after. In view of the fact that the drug is a stimulant, it should be dispensed with caution.

Physio-therapy Service: This service is a most valuable adjunct to the medical care of the inmate. It, too, can be administered by the trained inmate. Caution naturally must be exercised in preventing the indiscriminate prescribing of certain "luxury treatments". Inmates about to be released seek ultra-violet ray therapy in order to obtain a "sun-tan". The modern prison provides the inmate with as many if not more

opportunities for exposure to sunshine than members of the civilian community ordinarily receive. Hence, it seems a bit unrealistic to provide a service which is not available to most members of the local community. Naturally, it is recognized that there are chronic disease states in which general irradiation is indicated. Another "luxury treatment" is the use of the sweat box for weight reduction, when a simple exercise consisting of pushing one's self away from the dinner table a little sooner would accomplish the same purpose.

Special Problems—Sick-Call: Prison medicine has problems which are not ordinarily encountered in the civilian hospital because of the fact that its clientele is derived from a large group of men who must adhere to a certain daily schedule of eating, working, and sleeping. Some of the special problems encountered in the prison situation will be discussed.

All disciplined organizations having large groups of men have found it necessary to set aside one period of the day in order to permit contact with the medical department. The time of day selected usually varies to meet the local situation. In general, however, it has been found most expedient in prison work to select a period when inmates are not engaged in work. Usually, this period is not so very long so that ordinarily only the simpler, less time-consuming examinations and treatments can be given by the medical staff. If more time is needed for examination or treatment, it is best to schedule the patient for an hour when these procedures can be conducted in an adequate fashion.

The out-patient sick-call in the prison should be modeled after the out-patient service in the civilian hospital, with the exception that in the interest of economy in time a physician should initially see all patients. A physician is designated for this position, as it is believed the responsibilities are more than sub-professional personnel should be expected to assume. Experience plus acquaintance with the inmate body will immediately suggest to the trained physician the best disposition of each case. Many minor disorders can be prescribed for on the spot. However, it will be necessary to refer from one-half to

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two-thirds of the attendants of the daily sick line to the various clinics, either for more careful examination than is possible on the sick line, or for special treatments as in the E.E.N.T. clinic, Surgical clinic, Medical clinic, etc. The great majority of inmates attending sick call represent less than twenty per cent of the population. Members of the Custodial force have often commented on the fact that a large per cent of the sick line participants represent disciplinary or other type problems in their department. This is only natural and to be expected, as maladjusted personalities are usually not conscious of the motivations which cause the maladjustment. They know that something is wrong and they are floundering about in a dilemma, somatizing various complaints in an effort to achieve some degree of comfort. It is interesting to note how often relief is obtained from some chronic disorder by change of work assignment, solution of family problems, etc.

Certain evils secondary to management of the sick call must be anticipated. Many inmates have a tendency to prescribe for their own ailments. Such attempts should be discouraged, as it reflects upon the ability of the physician to treat, as well as because it causes wastage in medicaments. A certain percentage of inmates wish to be excused from work for non-medical reasons. This should be discouraged, as it reflects upon the professional integrity of the physician. Carefully kept sick-call records are the best assurance against granting excusal from work to malingerer and to those not entitled to this privilege. In case of doubt as to the validity of the request for excusal from duty, there is no substitute for a careful examination.

Sick-call records should not be entrusted to the care of the patient, as this discourages the staff physician from making frank comments which may be utilized later by his colleagues.

Emergency Requests For Treatment: Regardless of the hours during which sick-call is conducted, it will be found necessary to make provision for the medical care of those inmates who become suddenly ill at other hours, or who are not able to attend because of institutional duties. Many inmates ask for

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emergency attention for various reasons, such as to enable them to escape certain duties at their work assignment, or in order to gain special attention. Such requests should be denied, and the inmate's attention called to the proper procedure. If the number of requests for emergency attention reaches an excessive number, the Chief Medical Officer should point out to the inmate that his conduct is reflecting on his institutional record.

Annual Physical Examinations: Prison inmates as a group appear more concerned about their physical well-being than most members of the civilian community. For this reason, it is important that an opportunity be given for an annual physical examination, similar to that given at time of admission to the institution. Such examinations can be scheduled just prior to the time of the annual review of the prisoner by the Classification Committee. It is surprising the number of medical and surgical conditions requiring correction which are unearthed in this manner in that part of the inmate population which rarely attends the institutional sick-call. Annual physical examinations are also good preventive medicine, as many potentially serious disorders can thus be detected in their incipency and treatment started early.

Conclusion: In spite of the necessity for the prison physician to be constantly on the alert in order to prevent abuses of his good nature, prison medicine is a satisfying career. There are many worthy members of the inmate body who are worth salvaging for useful lives in the community, and who appreciate the professional efforts made on their behalf.

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THE INTRAMURAL PRACTICE OF EYE, EAR, NOSE, AND THROAT

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The practice of eye, ear, nose, and throat, as with all other prison medicine, resolves itself into the treatment of the definite pathology of these organs, and the recognition of the psychomatic complaints connected with them. In the institution in which the author serves, approximately fifteen per cent of the total visits to the hospital and about fifteen per cent of the surgery performed are for complaints referable to the eye, ear, nose, and throat. Recognition of the existing psychic disturbances is often difficult but extremely important in outlining a course of treatment and evaluating the results obtained. For example, the individual who complains of headaches may have a mild chronic sinusitis but may obtain incomplete relief because the basic difficulty is a so-called "tension-headache" brought about by some situational or emotional upset. The prison community contains a higher percentage than the general population of individuals who are emotionally unstable. These individuals are confined in an atmosphere laden with many stresses and strains which they meet by somatizing their difficulties. The physician practicing E.E.N.T. in prison must recognize this situation and temper his diagnoses accordingly. In a paper of this type, only the more commonly encountered eye, ear, nose, and throat problems, and those requiring special consideration in prisons will be discussed.

Because the medical staff of most prisons is composed of only a few physicians, it is usually impossible to have a full time specialist for eye, ear, nose, and throat. It is true that most of the patients coming to the E.E.N.T. service can be competently treated by a general practitioner. However, the occasional patient presents a problem where the services of a consultant specialist is advantageous both to the patient and to

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the physician. Persons who accept philosophically the loss of a finger or another member of the body are panicked by the anticipated loss of an eye, or loss of vision or hearing. The services of a specialist do much to maintain morale and to protect the physician from legal repercussions. In addition, much of the reconstructive surgery which may better equip the individual for a useful life at the time of his release should be performed only by a thoroughly trained specialist.

Inmate help can be trained to perform many of the routine treatments and examinations. The inmate chosen should have above average intelligence, a sense of responsibility, manual dexterity above the average, and a sufficiently long sentence to allow for adequate training. The duties which he performs are comparable to those performed by the nurse or trained attendant in the office of the outside specialist. His duties include routine tests for acuity of vision and hearing, the administration of prescribed medications, adjustments and repair of glasses, and the keeping of records.

With the special conditions existing in prison, many of the medications which would ordinarily be prescribed for self-use by the patient are, of necessity, administered only in the hospital. Where drug addicts are incarcerated, as they are in most prisons at some time or another, ordinary eye droppers are kept in the hospital and closely watched because, attached to a needle, they serve well as a syringe for the intravenous administration of drugs. All medications should be dispensed in small amounts so that the unused portion is kept to a minimum and not wasted. Expensive drugs are needlessly wasted when dispensed for use in quarters. A few of the medications are potentially dangerous if taken in overdosage, or by mistake, and are given only in the clinic. Because these precautions are necessary, the number of visits to the clinic is increased above that which would be expected in ordinary practice. A trained attendant can properly administer these treatments and save a physician's time for more profitable use. The routine tests for visual and auditory acuity which are performed at the time of the admission physical examination can be competently exe-

cuted by the attendant. These tests are valuable in determining which individuals will require further attention, and also serve as a record if any disability is later claimed. At the time of commitment, a careful physical examination is done by the physician. This includes a routine examination of eyes, ears, nose, and the throat. Any deviations from normal are noted and treated later as indicated.

Patients with acute upper respiratory infections comprise a large share of the visits to the E.E.N.T. clinic. These are treated on the daily sickline with vasoconstricting nasal spray or nasal drops, and salicylates either in the form of sodium salicylate with sodium bicarbonate or aspirin. The ephedrine or ephedrine substitute nasal drops are used in the clinic but are rather expensive to dispense for routine use in quarters. With most of the population confined to the inside during the winter months, the air which is breathed usually is very dry and, in spite of many theoretical contraindications, patients obtain more relief from oily than from saline nasal drops. A camphor-menthol preparation in oily solution is dispensed in half-ounce bottles and has been found adequate. The corks of these bottles, when grooved with a razor blade on two sides, permit an even flow of the solution. If pharyngitis or tonsillitis accompanies the upper respiratory infection, it is treated with local applications, such as tincture of benzoin, while the alkaline antiseptic type of gargle is prescribed for use in quarters.

Acute upper respiratory infections of epidemic proportions are seldom encountered. If necessary, all infected individuals can be confined to their quarters at the onset of their symptoms. As a rule, only those individuals who have complications of upper respiratory infections are hospitalized. In the protected atmosphere of prisons, exposure to extremes in weather is not a problem, and most individuals have an adequate amount of time for rest. Moreover, in the prison situation there is probably little more chance of spreading the upper respiratory infection by keeping the patient at work than by segregating him. Where the individual is quartered in a

dormitory, he may come in contact with more individuals than he would at work.

The complications of upper respiratory infections such as tracheitis, bronchitis, eustachian tube catarrh, otitis media, laryngitis, and sinusitis, are less easily treated. Cough, huskiness of the voice, and the irritating phlegm in the throat are seldom improved until the post nasal drainage is relieved. Steam inhalations, throat irrigations, and continued use of the nasal drops usually give relief. Acute sinusitis is treated by the numerous methods for promoting drainage. Silver protein preparations such as argyrol or ephedrine solutions, when used as packs, are a reliable standby. The newer combinations of sulfa drugs and synthetic ephedrine preparations give relief when used several times a day with the head in the proper position. Very rarely does the use of surgical interference, suction, or irrigation seem justified. If there is any appreciable temperature elevation or the patient appears toxic, the oral administration of one of the sulfa drugs is indicated.

Sore throats which last longer than forty-eight hours or deviate in appearance from that ordinarily encountered should have further study. The more serious lesions such as the blood dyscrasias, syphilis, tuberculosis, diphtheria, or malignancy should be considered. If there is an elevation of temperature, smears should be taken and sulfonamide drugs given orally as indicated. Laryngitis which does not respond readily to treatment should be investigated with laryngoscopy. Tuberculosis, syphilis, malignancy, or nerve paralysis may be among the reasons for the continued hoarseness or inflammation. Otitis media may be prevented in some cases by early and continuous use of vasoconstrictors, hot gargles, and steam inhalations to promote patency of the eustachian tubes. When sulfonamide drugs are used for acute otitis media, and symptoms persist more than two weeks, a careful check should be made for signs of mastoid disease.

Chronic sinusitis is the basis for many of the recurrent symptoms found in patients referred to the E.E.N.T. clinic.

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Conversely, definite evidence of sinus disease should be manifest before the diagnosis of sinusitis is made. Individuals with pathology in other regions, or those with symptoms due to nervous tension, are definitely harmed by having their attention fixed on their sinuses.

When the origin and course of the nerve supply to the sinuses is recalled, it follows that pain can be referred reflexly through the branch of the fifth nerve to any of the areas supplied by that nerve.

Many of the complaints referable to the eyes have their basis in infected sinuses. The recurring episodes of conjunctivitis, pain commonly described as "behind, or around the eyes," the sensation of heaviness of the eyelids, the recurrence of hordeoleums or chalazions, are all frequently traced to persistent sinusitis. The feeling of fullness in the ears, cracking of the ears upon swallowing, intermittent buzzing or ringing of the ears, sharp pains just beneath the angle of the jaw, itching in the floor of the ear canal, may all be due to the inflammations surrounding the nasal end of the eustachian tube, caused by post-nasal drainage from sinuses. The retracted, reddened eardrum and the accompanying earache frequently begin with a eustachian tube catarrh. If this is not relieved, frequently a purulent otitis media follows and results in a perforated drum and draining ear. The post-nasal drainage may be responsible for the dry, irritated throat, the recurrent attacks of tonsillitis, and laryngitis. By the same process, bronchitis and tracheitis may originate from continued irritation of the tracheo-bronchial tree. The common symptoms of a productive cough after first arising, of the "after-breakfast" cough, and the sensation of morning nausea or mild gastrointestinal symptoms may be due to the chronic post-nasal drainage into the tracheo-bronchial tree or gastro-intestinal tract.

The problem of the etiology and treatment of chronic sinusitis is complex. Mechanical abnormalities such as a deviated septum, spurs on the septum, polypi or hypertrophied turbinates may cause obstruction to drainage. The rich plexuses of veins and arteries supplying the nose and the throat

are affected by all the factors which influence vascular changes. Sensitivity to changes in temperature, change in position of the body, allergic manifestations, and sensitivity to foods, air-borne allergens, and bacteria, emotional and endocrinal disturbances all affect the blood supply of the nasal mucosa. It is increasingly recognized that chronic sinusitis frequently has an allergic basis. As with other allergic manifestations, the emotions play an important part. A person in prison is more likely to be emotionally disturbed, and on that basis is more likely to have manifestations of all basic allergic predispositions. It is also recognized that emotional changes by themselves affecting the sympathetic nervous system cause variation in the blood supply to the nasal mucosa. It follows logically that, in response to this allergy or vasomotor changes accompanying emotional disturbances, the blood supply to the nasal musosa deviates from normal, the opportunity for infection is increased. If the mucosa lining the sinus becomes swollen, the sinus ostia narrowed, the circulation of venous blood slowed, and the normal ciliary action impaired by the poor blood supply, the conditions are then favorable for the incubation of the infection.

A boggy, pale muscosa of the nose suggests an allergic basis for the nasal congestion. Smears of the nasal mucosa, where allergic rhinitis or sinusitis is suspected, usually show an eosinophilia. X-rays of the sinuses may aid in determining which sinus is principally involved and help in ruling out any abnormality in the structure of the sinus or any complication of the disease, such as osteomyelitis of the sinus wall, polyposis of the sinus itself, or abnormally long tooth roots extending into the sinuses. Transillumination is a valuable aid in diagnosis.

The treatment of chronic sinusitis should include correction of existing mechanical abnormalities, removal of as many sources of irritating allergens as possible, and improvement of the general and mental health of the individual. Individuals in prison probably smoke more than those in the general population. While the amount of irritation occurring is debatable,

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it seems reasonable that persons having swollen and irritated mucous membranes should smoke in moderation, if at all. Testing individuals for sensitivity to the multitudes of possible allergens poses a tremendous task. In prison, it is very difficult, if not impossible, to make available to all those with chronic sinusitis special diets, special clothing provisions, special work assignments, and other special considerations to avoid the allergens once they are determined. If some specific allergen is known, attempts are made to avoid it. Neither specific nor non-specific desensitization has proven particularly satisfactory. Most patients obtain relief from the use of vasoconstricting nasal drops to relieve venous congestion, artificially induced heat to increase the blood circulation, and analgesics for pain. Silver protein nasal tampons, employed daily for a week at a time, or the combination of sulfathiazole and ephedrine nose drops or packs, are helpful. Sometimes a course of sulfonamide drug by mouth will temporarily improve the condition of the sinuses and the general health of the individual. Vitamins, iron, and general supportive measures to increase an individual's resistance to infection are helpful. Psychiatric consultation and treatment is frequently to be recommended. Many of these individuals who can be helped to regain their mental composure find that their sinuses are improved.

A few individuals who are having difficulty either because the deformity causes obstruction to breathing or discomfort are definitely helped by plastic procedures on the nose. Plastic surgery of the nose should be carefully considered before it is performed in prison. Individuals who are pugilistically inclined should not be operated upon until their personalities have stabilized. Any effort to change the appearance of the individual is discouraged by the authorities unless there is some definite advantage to be gained. Occasionally an individual will develop a personality problem because of the disfigurement involved. Such an individual may be helped by improving the general appearance of the nose. These operations are frequently difficult to perform and not always completely satis-

factory to the patient. They should always be performed only by a qualified specialist.

The operation of tonsillectomy is frequently requested in prison. The majority of individuals in prison have passed the age when tonsillectomy is most commonly indicated. Those who have frequent attacks of tonsillitis, especially if these attacks are complicated by peritonsillar abscess, or systemic symptoms such as arthritis or rheumatic fever, are benefited by tonsillectomy. Some of those with persistently reddened anterior tonsillar pillars, or those whose tonsils are so enlarged that they become mechanically irritated, are definitely improved by their removal.

Chronic suppurative otitis media usually requires long periods of treatment. General therapy includes removal of foci of infection such as tonsils and adenoid tissue, treatment of paranasal sinus disease, and improvement of the general health. Local cleansing of the discharge with suction or dry swabs, the use of boric and alcohol drops, sulfathiazole powder or boric and iodine powder insufflation, or sulfathiazole in glycerin drops are helpful. The use of penicillin locally has been tried, but it seems to offer no marked improvement over the older methods of treatment. Insufflation of the eustachian tube may be indicated. Patients with polypi or granulated tissue formations should have these treated. Occasionally a mastoidectomy is indicated.

Middle ear deafness which impairs hearing to a marked degree should be corrected with hearing aids. It has been commonly recognized that, while the loss of hearing does not handicap the individual as much as many other defects, the deaf person is much more suspicious and is more likely to develop a persecution complex. Hearing aids may prevent serious personality problems. Here again, however, institutional authorities should be consulted because of the expense of such apparatus and any special considerations a particular case offers. As has been mentioned before, not infrequently the presence of a chronic eustachian tube catarrh is the basis on which a draining middle ear and chronic middle ear deafness develop.

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It seems logical that careful attention to the prevention and treatment of this chronic eustachian tube catarrh is indicated in all middle ear disease.

External otitis, while not serious, is frequently annoying. This may be due to a definite purulent infection or may be in the form of an eczema or fungus infection. The purulent infections are treated conservatively with sulfonamide drugs and heat. The fungus infections and eczema type eruptions are quite satisfactorily treated either with salicylic in alcohol or salicylic in cold cream in the majority of cases. We have found quinolor ointment and gentian violet solution to be a definite aid in some individuals. Ultra violet light aids in drying the weeping which occurs.

The individuals with abnormally prominent or otherwise deformed ears, who are acutely conscious of this deformity, may be helped with plastic surgery which aims toward its correction. It does not follow that all individuals with prominent ears should be urged to have them corrected, but only those who have some definite personality problem because of them.

There is a larger percentage of the prison population wearing glasses than in the same age group in the general population. This may be attributed to several causes. The lighting facilities in prison usually produce glare, and frequently there is an inadequate intensity of light. This makes more apparent any existing defects in vision. Most individuals read more while incarcerated, and for this reason any slight defect becomes manifest. Inmates in general feel that, while they have time and glasses are furnished free of charge, they are neglected if not fitted for them. Some inmates attempt to use poor vision as an excuse for not doing the work assigned to them. The "tension headaches" are at times confused with visual defects, and, as has been noted before, sinusitis is frequently a cause of complaints referred to the eyes. Careful refraction, the use of the retinoscope and the ophthalmoscope, will make it possible for the general practitioner to obtain a correct prescription in the majority of patients. All patients with abnormal vision should be carefully checked with the

ophthalmoscope for pathology other than refractive error. Those occasional cases which are more difficult to refract can be seen by the consulting specialist. Properly fitted glasses are an important contribution towards making the individual comfortable during his period of incarceration, and making possible his return to a useful, self-sufficient existence in free society. Refraction is a painstaking and time-consuming procedure, but the results justify the effort.

Occasionally the impact of incarceration may cause a flare-up of a quiescent glaucoma or eye infection. These must always be considered when there is pain or inflammation about the eye. They can be treated by the accepted methods. However, when the response to treatment is not satisfactory, a specialist should be consulted promptly.

Corrective operative procedures about the eye mean much toward rehabilitation of the inmate. The individual with strabismus is always conscious of this defect and becomes an object of pity or curiosity. Correction of strabismus surgically, or with the proper glasses when possible, will mean much to the individual when he again takes his place in society. The same is true of traumatic cataract in the younger inmate. A sightless eye, when disfiguring, may be removed and replaced by an artificial one with marked benefit to morale and a lessening of the possibility of sympathetic ophthalmia. In the older individual, the removal of senile cataract and replacement with correct lenses may permit the patient again to become self-sufficient. Scars and contractions about the eyelids, if corrected, may remove a source of acute embarrassment and discomfort as well as aid in preventing more serious complications such as corneal ulcer. These eye operations obtain cosmetic as well as physiologic improvement and may, indeed, change the outlook of an inmate. Because of the responsibility involved, all eye surgery should be done by or under the supervision of a competent specialist.

The accidents which occur occasionally in the repair shops or industries connected with the prison should be treated immediately and meticulously. Perhaps the most common of the

THE INTRAMURAL PRACTICE OF EYE, EAR, NOSE, AND THROAT injuries here involve foreign bodies in the eyes and welding flashes. The foreign bodies, unless they are very superficial, should always be removed by a physician. In some cases where the foreign body has been deeply imbedded, physiological rest by the use of atropine is indicated. Welding flashes usually respond well to the use of an anesthetic solution such as butyn, and a mild emolient such as castor oil. The more severe burns may require atropine and an eye patch. Lacerations, or foreign bodies entering the eye, should be promptly seen by a specialist.

The aim in this paper has not been to cover completely the practice of E.E.N.T. in prison, but rather to emphasize the more commonly encountered problems. The physician who practices E.E.N.T. in prison sees more of the psychosomatic complaints and fewer of the more serious organic diseases. With no very young individuals, and only a limited number of individuals in the old age group, the incidence of the various complaints is different. The psychosomatic aspect of the symptoms referable to the eye, ear, nose, and throat must constantly be kept in mind. Careful diagnosis is extremely important. If individuals who have somatized their psychoneurotic disturbances are treated for organic disease by mistake, it tends to fix their psychoneurosis and makes more difficult their treatment by psychiatric methods. All treatments should be evaluated as to their effect upon the individual as a whole.

THE ACUTE MEDICAL PATIENT

ROBERT W. BLACH, M.D.

It is likely that most doctors who are called upon to treat an acutely ill patient think with regret that the acute illness might have been prevented if adequate protective or preventive measures could have been instituted. However, the doctor in a prison need not have that regret. The main purpose of the prison medical administration is to prevent illness, acute or otherwise. A discussion merely of the methods of treatment of an acute medical patient in the prison is not complete unless one discusses also the measures taken to prevent acute illness. The object of this paper is to explain the mechanism of the prison hospital and its service to the institution, and to describe the treatment of the acute patient, with emphasis on the differences between treatment in prison and in the "free world." The preventive aspects will be discussed and described first.

When the inmate enters a Federal institution he is "dressed-in" at the receiving section of the prison. All of his own clothes are removed; he is given a shower, weighed, fingerprinted and particular body identification characteristics are noted. A member of the hospital staff is called while the man is undressed, and he is given a preliminary physical examination to determine the presence of disease which might be dangerous to the inmate population or to himself. A brief past medical history is also obtained. If there is suspicion, or evidence of contagious disease, he is immediately admitted to the hospital with isolation precautions. Almost all such admissions are for gonorrhea or primary and secondary syphilis; occasionally a case of measles, mumps, a decompensated cardiac or severe diabetic is discovered. The new inmates who are seemingly healthy are sent to quarters in the quarantine building of the institution. In the larger penitentiaries, this is a

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separate building, while in the smaller institutions it is usually a part of the cell house which is used to house the close custody inmates. Men upon admission remain in this section of the institution for periods of from two weeks to one month, the shorter period being for those with less than a year and a day. During this quarantine period they are interviewed by the various prison department heads. At this time the men are called to the hospital for a complete physical examination, consisting of weight, height, blood pressure, eye examination and a general physical check up. All previous illnesses, injuries and operations are recorded, and the need of any medical or surgical treatment is noted.

In southern stations routine examination of feces for hookworm is performed. The number of positive findings reveals the value of such a procedure. Prompt treatment of such infestations result in better health of the inmates affected and, by increasing their resistance to disease, may prevent an acute illness later on.

During the quarantine period a brief orientation lecture by one of the doctors on the hospital staff, preferably the Chief Medical Officer, is recommended. He explains the role the hospital plays in the inmate's institutional life. This can save much misunderstanding later.

Following this series of examinations in the various departments, each department sends a summary of the results to the classification supervisor, and at the time of the inmate's completion of his quarantine period he meets the classification board to be assigned to work; these findings are used as a guide in choosing the type of work most suitable for each man.

When the admission routine is completed the inmate has a number of ways to contact the hospital. However, some men do not like to visit the hospital and will spend years in an institution without consulting the doctors. In long term institutions a yearly routine examination of all inmates is advisable. This examination, though not elaborate, should include a urine examination, height, weight, blood pressure measurement and cardiac auscultation. A few questions regarding health during

the past year should be included. In this way, occasionally a diabetic or tubercular can be found before he is seriously ill. By means of such procedures, most incipient illness can be discovered early enough to prevent serious disability. Yet, sudden illness will appear despite the most elaborate preventive efforts. The management of such illness is an important part of the prison medical work.

When inmates become sick in the institution they have a number of ways to receive medical care. If they fall unconscious or sustain a severe injury, or in any way show symptoms so severe that there is no question regarding their illness, they are usually carried to the hospital by order of the custodial staff. Sometimes the doctor is called if it is thought to be dangerous to move the patient. If he can be moved, however, he is taken to the hospital on a stretcher. If necessary, treatment can be given at the place of injury or illness. This would consist usually of plasma for shock, or temporary splints for fractures, with perhaps an injection of morphine.

If the illness is not as obviously acute as above, the inmate can ask for an emergency pass which will allow him to visit the hospital at other than the specified clinical hours. This pass is obtained from his detail officer, any custodial officer, or the custodial administration center, such as the captain's desk or captain's office. The inmate brings the pass to the hospital where the officer on duty checks it and refers the man to the medical officer in charge of emergencies, the Officer of the Day. Small institutions may not have a custodial officer on duty in the hospital in which case the doctor sees the man as soon as he has time. This matter of emergency visits to the hospital is a constant problem and warrants some detailed consideration.

As pointed out in the chapter on malingering, the hospital is used as an instrument to avoid work by many inmates; an emergency pass usually results in at least a half-hour off work, and frequently longer if the hospital is busy at the time. If many men come to the hospital on emergency passes during the day, the work of the institution is hampered, and hospital rou-

tine is upset. Yet one obviously can not prohibit such visits for occasionally serious harm or death might result from lack of prompt medical care. The problem is more serious in small institutions, especially those of minimum custody, because the inmates are able to move about at will much of the time and "drop in" on the hospital any time they feel like it. Even if they do not look ill, they can't be sent away unless the doctor sees them and is satisfied that no emergency treatment is needed. All this takes time and interrupts the doctor, who may be the only medical officer in the hospital. The more rigid supervision in larger institutions tends to discourage these casual visits. In any type of institution there are measures which can be taken to alleviate the problem.

The first step toward decreasing unnecessary emergency visits can be taken during the initial orientation lecture to new inmates. They should be told about the proper time to visit the hospital, which is at sick-line time. The importance of maintaining hospital routine for their benefit should be explained, and also how unnecessary emergency calls interfere with the efficiency of the hospital and thereby make it impossible for the hospital to do as much for the inmate as it would like to do. The meaning and proper use of emergency passes should be indicated.

In addition to explaining the meaning of emergencies to inmates, the custodial officers should be told how they can be of aid. Some officers tend to be too lax, allowing men to go to the hospital at any time, while others never allow men to go to the hospital, even when it is necessary. The logical method the officer should use is to ask the man who has requested an emergency pass why he needs to see the doctor. Frequently the inmate merely wants a cathartic, a headache tablet, or to have his spectacles tightened, or any one of a number of reasons, none of which require emergency treatment. Such men should be refused a pass but should be told to visit the hospital on the regular sick line. If, however, the inmate insists that he is too sick to be able to work, it is safer for the

officer to send the man to the hospital than to assume the responsibility of deciding how ill he really is.

Another measure which can be taken, especially in institutions where there is a large evening or night shift, is to conduct an extra sick line daily for men who are working at the time of the regular sick line. This assumes that the regular sick line is held in the afternoon. (The most effective time for the sick line will be discussed later.) The extra sick line can be conducted about 1:00 P. M. One more method of alleviating the load of the out-patient clinic in the hospital during the morning is to allow the men who claim they are unable to work due to severe colds, sore joints or other illnesses which do not require immediate treatment to leave their work details and remain in quarters until the extra sick line. This is really a war-time expedient, for hospitals where there may be only one doctor who has to spend much of the morning operating. By applying one or more of the above methods, a fair degree of control over the emergency load can be maintained.

Inmates who are not acutely ill sometimes do not come to the hospital on an emergency pass, yet do not want to attend the regular sick line. They may want to discuss something at greater length with the doctor than is possible at sick line time. For such men another procedure is possible. The inmate can fill out a slip requesting an interview with one of the doctors. When the doctor receives the request he sends a call out to the inmate for some time during the week, which he has set aside for this type of interview, and which can be used to advantage in routine staff work when there are no interviews to be granted. It is important to answer such requests promptly, because such requests may come from men who are mentally agitated, and a prompt interview may prevent an acute psychotic episode, suicide, or an attempt to escape.

Occasionally a custodial officer notices unusual behavior on the part of an inmate and calls the hospital: in such a case it is important to examine these men promptly, both to determine whether the inmate in question is ill, and to encourage such observation on the part of the custodial staff. Some-

times an inmate working in the hospital will tell the doctor about some other inmate who is ill but who does not want to come to the hospital. Although the first reaction on the part of the doctor might be to send for the inmate immediately, it is best to hesitate. The hospital orderly should be told to explain to the other man that he should come to sick line, or send an interview slip. This is necessary, unless there is reason to believe that the other inmate is acutely ill, because a "racket" may be in process of being worked on the other inmate. Hospital orderlies sometimes tell men in the general population, especially new men, that the doctor is too busy to see them, but that for a slight consideration, such as a package of cigarettes, an interview will be arranged. New inmates can thus be fooled into paying for services which they would get merely by coming to the hospital themselves. The prison doctor must always be on guard to avoid involvement in such "rackets."

The greatest bulk of medical care is dispensed on the daily sick line. This corresponds to the "sick call" in the army camps. The organization of the sick line varies in different institutions. Sometimes one doctor handles the entire line. This is usually the case in the smaller institutions where the daily sick line consists of not more than thirty patients. However, in larger penitentiaries, as many as two hundred men may attend sick line. One doctor can not possibly do justice to so many patients. The best arrangement is to have one doctor interview all men on the line, dispense any simple medicine such as aspirin or laxatives on the spot, and refer all cases requiring further examination to the other members of the hospital staff who are in their respective offices nearby. Thus a large volume of patients can be handled in less than an hour without sacrificing medical standards of thoroughness.

The sick line, usually held daily, except on Sundays and holidays, is an important part of the hospital routine. The time of day it is conducted is important. Several factors must be considered, including the best time for the hospital staff, the desires of the warden, and the requirements of the institu-

tion in general. Since attendance at sick line gives opportunity to break the prison routine, many men come to the hospital merely to do something different, and possibly get an hour off from work, especially if they are assigned to a job they do not relish. Such practices should not be encouraged, yet attendance on sick line must never be made a hardship. The object of having a prison hospital is to give medical care, and this can not be achieved by placing too many difficulties between the inmates and proper attention. However, a logical compromise can be reached. In private life, one visits the doctor at times which do not interfere with one's own work. In institutions a similar realistic attitude can be maintained by holding sick line at a time when men would ordinarily be enjoying recreation. If a man is ill, he will not feel like playing ball anyway, yet those who go to the hospital for want of something else to do will think twice before foregoing their recreation period. Some people more extreme in attitude have advocated holding sick line at meal time. This is too drastic and does mean a hardship for men who want to see the doctor.

During sick line, acute illnesses are often encountered. Such cases are immediately hospitalized. The prison hospital is well equipped to handle most illnesses, however severe. There are open wards and private rooms, including strip-rooms for acute psychotics. These strip-rooms are devoid of detachable fixtures which the patient could use to harm himself or others. The windows are protected by heavy wire screens. Unfortunately, such rooms are never ideal. In fact, the author has never seen an ideal strip-room, even in mental hospitals. The designers have always underestimated the ingenuity and determination of the psychotic patients, and either have window screens too flimsy, or leave light bulbs exposed, or have blind spots in the room which can not be observed without opening the door. Perhaps some day psychiatrists will be consulted when such rooms are to be designed.

The hospital patient in prison presents some differences from the patient entering a hospital in the "free-world." While most patients entering a hospital on the outside are entirely

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new problems to the hospital staff, the inmate in the prison hospital rarely is. He has usually been given his initial physical examination; his past medical record is known as well as any records of admission in other hospitals. For this reason the elaborate hospital admission examination is not at all necessary. The time can be spent in examination of the particular system which seems to be affected. The laboratory, which is available at all times, is called on for prompt urine analysis and blood count, with additional studies such as blood chemistry if needed. X-rays can be taken. Occasionally a bedside X-ray is needed. Most institutions do not have a portable X-ray other than a portable dental X-ray unit. However, satisfactory chest plates are possible with such an instrument. Consultation between the various medical branches in the hospital are always advisable when a patient presents a diagnostic problem. Fortunately, prison medical staffs are never large, and members usually work closely together. If the diagnosis still remains in doubt, outside consultants can be called upon. Most prison hospitals have several consultants on the staff. These men receive a small yearly salary, and as a rule are very cooperative when called upon. During the war emergency, these men were busy with their own practices and were called only when absolutely necessary. Sometimes it is possible to send the patient to them rather than have them come to the institution. This practice is more often to be found in the minimum custody institution than in the larger type penitentiary.

The acute illnesses in prison are, as a rule, not too difficult to handle. The patients are in fairly good condition, due to regular living habits and conditions in institutions. Pneumonia is rare because patients with upper respiratory infection are usually hospitalized before pneumonia develops. Sulfadiazine and penicillin control most pneumonias that do develop. Acute cardiac decompensation is rare, because the cardiac patient is supervised at all times and his work is carefully selected to prevent undue exertion. Diabetic coma and insulin shock

also occur rarely, and the doctor is called early enough to administer the routine treatment to control the disorder.

There is one type of acute illness which does present serious problems in prison—the acute psychotic, the acute hysterical and the suicidal. Among the acute psychotics are found mainly schizophrenics, paretics, and rarely, manic-depressives. Acute anxiety is also occasionally encountered, usually acute homosexual panic. Most suicidal attempts are either malingering or hysterical, although occasionally a depressive attempts suicide seriously. All these cases require hospitalization, some require strict suicidal precautions. The proper management of all psychotic cases is difficult for several reasons. The psychiatrist has difficulty establishing rapport because he is part of the official system which is keeping the man locked away from society. The custodial staff, and frequently some of the civilian hospital assistants, have no clear idea of how to handle psychotic patients. Many have been trained in the old school of “treat ‘em rough.” In addition, many custodial officers will not accept the diagnosis of psychosis unless the patient is a gibbering idiot. If the patient makes one rational remark the immediate reaction is, “He’s not crazy, he just talked to me as sensibly as anyone.” If the officer believes the man is faking the psychosis, he will not treat him with the consideration the psychotic deserves and needs. There are other aspects of psychotics which many doctors do not always realize. Two popular fallacies are too often quoted as truth:

“If the patient says he is crazy, he is sane.”

“If the patient says he is going to commit suicide, he will not do so.”

Both of the above statements are absolutely false. Many psychotics, both schizophrenics and depressed manic-depressives, often realize that something is happening to their minds. They are horribly frightened by it and often state that they fear insanity. Many depressed manic-depressives will say they intend suicide, and they mean it. The hystericals also speak freely of suicide. Although they do not really intend to carry it through they may make a mistake and kill themselves during

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an hysterical suicidal attempt, but often it is just that, a mistake. For this reason, it is vital that the doctor see any inmate immediately if he learns that the man has expressed fear of his own sanity or has spoken of suicide, regardless of the time of day or night the news is received. Immediate examination of the patient is important, not only to prevent suicide but to obtain information from the patient. Often an acute psychotic, especially a schizophrenic, will be able to express some of his fears rationally during the first few hours, before the illness renders him mute or too excited to talk reasonably or coherently.

The usual procedures practiced in mental hospitals are used in the prison hospitals. Sedatives, continuous flow tubs and wet sheets for body packs are administered to quiet the excited patient. Some psychotics remain uncontrollable for long periods. Such patients are usually transferred to the Medical Center for Federal Prisoners, where the staff is larger and better equipped to cope with such problems.

In general, the acute medical patient, with the exception of the psychotic, does not present a truly serious problem. Preventive measures ward off many acute illnesses, while those which occur are made easier to handle because of previous knowledge about the patient, as well as the patient's relatively good general condition which results from regular living habits within the institution.

THE REHABILITATIVE FUNCTION OF THE DENTAL SURGEON

HENRY W. HELBRAUN, D.D.S.

The relatively short span of the past fifty years has witnessed the evolution of dentistry not only as a highly specialized branch of medical care, but as a universal health problem. The invaluable contributions it has already made and will continue to make towards the health and welfare of mankind has achieved for it permanent recognition as a great human service. It should not appear unusual, then, to find a discussion of the role of dentistry and the particular aspects of oral hygiene in the problems of correctional medicine.

The treatment and rehabilitation of the criminal is primarily a behavior problem within the realm of the psychiatrist and psychologist; but experience has shown that the individual oral picture, in many cases, can have such a vital influence on the personality make-up that it is a definite obligation to thoroughly examine the mouth when investigating the social offender. This examination comprises a part of the inmate's physical report which is so necessary for his proper classification and any treatment prescribed for his ultimate rehabilitation.

Dental disease and malformations affect the general health of the individual to such an extent that in our programs of mental prophylaxis we must not fail to correct these conditions, or else be frustrated in our plans for rehabilitation. Literature is replete with the morbid effects of long continued dental neglect on the physical health and the minds of persons who are self conscious of their appearance. Moreover, the beneficial results obtained from appropriate treatment have been striking. If we are to socialize the individual and stimulate him to seek life's realities, we must rectify such physical deformities. Today when competition is at a maximum and

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one must be prepared both mentally and physically to acquire or retain any social or commercial position, a facial defect, in particular, constitutes a definite social and economic handicap. Dentistry in a penal institution, therefore, aims to correct all oral conditions that are detrimental to the health of inmates. This means not only their physical health but also their mental health, which is so important in the rehabilitation program. This would seem to indicate that the individual is composed of two distinct entities—the mind and the body—and treated as such, but let us not forget that this is done merely for a simplified practical approach to our problem.

Ever since the introduction of the structural concept of disease, a "mechanistic" philosophy of disease as a disorder of organs and cells has evolved. Illness has been separated from the psyche of man and the practice of medicine has become mechanized through specialties, precision instruments, and laboratory procedures. Dentistry, of all the specialties, has perhaps been most removed from the psyche. The dentist has long been called a "glorified mechanic," and such procedures as prophylaxis, fillings, extractions, dentures, etc. have never been associated with the personality of man. While it is not to be denied that medicine and dentistry have made great strides during this period of laboratory ascendancy, we must admit that the emotional side of oral sepsis has been sadly neglected. This has resulted in an incomplete understanding of diagnosis and therapy on the part of the dental surgeon, and a corresponding lack of appreciation of dental care on the part of the individual patient and the public as a whole. We can not divorce a man from his teeth or mouth any more than we can separate him from another part of his anatomy; no schism exists between a man's physical structures and his personality, which is the expression of the coordinated functions of those structures. Hence, any manifestation of structural or organic disease has a psychic corollary. Moreover, the conscious ideas of the effect of dental care on one's appearance, and the feelings of fear, pain and discomfort which, unfortunately, are associated with it, indicates that psychoneuro-en-

doctrine influences enter the picture of oral hygiene. Our methods of investigation and our techniques may be diverse and multiple, but the individual is always a unity.

Penal dentistry and the problems associated with it do not differ from any other type of dental service. In the Federal system the same high standards of conduct and workmanship that govern the profession are the guiding principles of all dental officers connected with the supervision and furnishing of oral care to inmates. The clinics and laboratory facilities are completely modern and equal to those found at military establishments or in civilian practice. Hence, it is not our purpose here to discuss diagnosis and therapeutics. These can be obtained far better from some of the excellent texts devoted to such matters. However, certain restrictions preclude some types of work, and the nature of the environment creates distinct problems of patient management.

In serving a large group of inmates with a slow but steady turnover, we must be guided by the following principles:

1. The restoration of the physical health of the inmate is imperative.
2. Due to limited personnel caring for so many patients, a practical consideration of utmost importance is the equitable distribution of service to all beneficiaries concerned.
3. The primary purpose is to provide the essential treatment to the greatest number of patients rather than to perform special operations or to construct extraordinary appliances for a few.
4. Not until the prerequisites of essential dental care are met can we give consideration to elective or esthetic oral rehabilitation.

The services concerned with physical health are mandatory obligations covered by the terms "routine dental treatment" and "limited prosthetic treatment." The former includes all work necessary to restore the mouth to a clean, healthy condition—prophylaxis, extractions, fillings, treatment for the al-

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leviation of pain and acute oral pathologic conditions, etc. The latter indicates full denture or partial denture prosthesis for utilitarian rather than esthetic purposes. Elective treatment refers to prosthetic replacements for the restoration of facial harmony and appearance in order to improve the patient's expression, attitude, and confidence in himself.

The amount of time and attention given to a patient will depend on such factors as the amount of work required, the urgency of treatment, the length of the inmate's sentence, and the size of the inmate population. The patient whose mouth is in very poor condition and who is serving a relatively short term will be given more frequent attention than the one who requires little work and has ample time for treatment. It is obvious too that the larger the inmate population the less time will be available to devote to the individual.

All service is absolutely free of charge. Inmates are not even permitted to pay for any special work, such as inlays, crowns, or fixed bridgework. This is as it should be in order to maintain a status of equality which is so important for the successful custody of inmates. Moreover, were this not so, the dental officer might be influenced by monetary consideration to favor those patients who are able to pay for such special services.

The inmate patient displays much interest in his dental work. He is usually very desirous of getting his mouth "fixed up," and takes advantage of all service offered him. While it is his prerogative to refuse treatment, there is only a small percentage of men who do so. The restoration of a badly decayed tooth, the removal of an aching infected root, or the "slick" feeling of a prophylaxis are concrete services that the inmate realizes and appreciates much more than others that are too intangible or abstract for his comprehension.

An inmate's refusal to accept dental care may be due to fear, usually resulting from previous unhappy experiences in a dental chair; ignorance of the nature of dental service and a failure to understand what is to be done (too many still feel that the dental officer is on duty merely to extract teeth); or

in some cases, religious reasons. It might also stem from a general attitude of intolerance and antagonism toward authority—a contrary emotional make-up that has developed from unwholesome environmental conditions such as a troubled home, poor discipline, and lack of understanding. A few moments should be spent in an honest effort to educate and advise such patients to the need of recommended treatment; and while such persuasion will often be of no avail, it may result in more than a few cooperative and thankful patients. The personal interest alone that is shown the inmate is a much desired and needed factor in his institutional life, and something for which he is grateful.

Among the inmates who refuse treatment there are:

1. Those who never seek treatment again.
2. Those who reconsider and request treatment.
3. Those who reconsider but wait until several days or a few weeks before their release to seek treatment, and expect the dental officer to rush the necessary work to completion.

Members of the first group are a closed issue and need never to be referred to again. Those in the second group should be welcomed back for appointments, but informed that they must now await their turn to be recalled at the convenience of the dental officer. The least consideration should be shown the last group; although the operator may render any service he sees fit to perform for them. Fortunately, there are very few who fall into this category. In all these cases, however, it is our moral and professional obligation to render emergency treatment for the relief of pain. When the inmate refuses treatment of any kind or is very uncooperative, a notation to that effect should be entered on his dental chart. Occasionally one encounters the "wiseacre" who complains to the warden or chief medical officer that he is not receiving the attention due him. The record will quickly settle any such controversies that may arise regarding a patient's demands for treatment.

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Failure to keep an appointment should not be construed as a refusal to accept treatment. Perhaps the inmate did not receive his appointment slip or was not immediately available at the time. However, if subsequent appointments are broken without explanation, the matter should be taken up with the custodial force to ascertain the cause. Often the inmate will report for his appointment but ask that treatment be postponed either because he is ill, because his presence is demanded elsewhere, or for some other reason. Such requests should be given due consideration, but if repeated, it can be assumed that the patient refuses treatment.

As a custodial measure, no treatment should be rendered an inmate unless he presents the appointment slip issued from the dental office or an emergency pass issued him by the officer in charge of his detail. This is done to discourage patients from coming to the dental clinic for reasons other than treatment or to seek advice at inopportune moments. Inmates desiring an interview with the dental officer should be made to request an interview in writing; following which an appointment will be given. This procedure is well suited to institutions where the inmate population is relatively small. However, in penitentiaries with a large population, it may be more practical to conduct a "dental sick line" once or twice a week where the inmate can air his complaints, seek advice, and arrange for an appointment. This will obviate the necessity of handling too many interview slips.

To insure efficient treatment and administration in the dental clinic, the following procedure of appointment control has been found to be most effective. After the inmate has had his primary dental examination, he is placed "on call" until given his first appointment by the dentist. The first meeting is devoted to a thorough prophylaxis. All necessary surgery is done at ensuing settings, and then the required operative work is performed. Finally, if the conditions warrant it, a prosthetic replacement completes the rehabilitation of the mouth. Inmates may, however, present themselves at any time for emergency treatment, which of course, takes precedence

over any appointments. This schedule of appointments, while proceeding through the various phases of dental care in order of importance, is not a rigid rule that must be adhered to. It can be **varied at the discretion** of the dentist for efficiency and convenience of operation to himself and the patient; but it should not be altered to suit the whims of the inmate who might want to dispense with primary treatment and secure less urgent therapy. It might be well to mention at this point that it is wise to have noted on the dental record the inmate's conditional release date to guide the operator on the length of time for treatment. Apropos of this, arrangements should also be made for the dental clinic to receive the "tentative discharge" lists that are regularly issued by the record office. This serves as an excellent check on men who have made parole, have earned additional industrial good time, have had their sentences reduced, or in general are to be released shortly. It will help the dentist to arrange his work accordingly for these patients in order to complete them before discharge.

The progressive phases of dental care are now more fully discussed.

Examination: After commitment to a Federal penal institution, an inmate goes through a quarantine period during which he is studied and prepared for the life he will lead under sentence. Among the personal articles issued to him at this time are a toothbrush and dentifrice for mouth hygiene; but many, in an attempt to maintain some individuality, prefer to buy their own supplies at the prison commissary. During this period he is given his primary dental examination which becomes part of his physical report. Except for full mouth roentgenograms, the examination is conducted as thoroughly as possible with a fine explorer and mouth mirror under an operating light. Roentgenograms are, however, taken when necessary during the course of treatment as a diagnostic aid and as an operative aid in locating and removing impactions, foci of infection, etc. The following information is recorded on the inmate's dental chart:—Caries, missing teeth, condition of mucous membrane, presence of fixed crown and bridgework

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or removable appliances, and any other significant or distinguishing findings. Pertinent remarks or recommendations regarding treatment can be entered at this time.

The alert operator will also take due notice of the oral cavity for signs or lesions that give a good indication of the patient's general health and reflect certain systemic disorders; *i.e.*, glossitis in pernicious anemia, scurvy in vitamin C deficiency, mucous patches in syphilis, aromatic breath in diabetes, etc. In this manner the dentist can be of invaluable aid to the physician and the patient for the discovery, diagnosis, and correction of systemic disturbances that may be undermining the individual's health.

A prevalent condition existing among newly admitted inmates is *gingivitis*. It occurs mostly in the simple marginal form, as a result of poor mouth hygiene, and very often in conjunction with an incipient or advanced case of "Schmutz-pyorrhoea." The more serious forms, like subacute and acute *Vincent's infection* are usually found on inmates who, before admittance, spent time in small county jails where such factors as poor diet, crowded unsanitary living conditions, and lack of recreation have caused a marked lowering of the patient's physical resistance. However, these cases respond very well to the proper treatment and improve rapidly once they commence regular living in a modern Federal penal institution with adequate diet, sanitary quarters, and healthy recreational facilities.

Acute or chronic gingival pathology is rare in the well adjusted Federal inmate. When it does occur, it is most probably due to arsenic or bismuth in the course of antiluetic treatment, and then only in those who have neglected proper mouth care.

After examination, the inmate is placed "on call" until he receives his first appointment.

Prophylaxis: Our purpose in devoting the first appointment to a prophylaxis is to remove all local irritating factors and restore the oral mucosa, as much as possible, to a clean, healthy, tonic condition. This will not only improve the appearance and well-being of the patient, but prepares the mouth

to better withstand postoperative infections following oral surgery. The removal of gross deposits around the teeth may also uncover hidden gingival caries and erosions.

Commonly associated with oral sepsis is *fetor oris*. It can be so unpleasant as to cause great concern to the patient, and in some individuals even may have a profound emotional effect. Hence, prophylaxis should not be considered merely from a toxic-infectious point of view, but also from the view point of a cosmetic and psychic reaction. Who will deny the marked improvement in appearance and the dramatic lifting of the malaise and mental depression of the "trench mouth" victim after therapy?

Prophylaxis is often attended by considerable bleeding of the gingivae. This should be explained to the patient as desirable since it relieves much of the congestion of the tissues.

Routine prophylaxis is a procedure which lends itself well to the trained hand of a dental assistant, (this is not to minimize the importance of the prophylaxis) but, just as in private practice where it may be performed by a competent dental hygienist so that the dentist will be able to devote his time more gainfully in other work, so can it be relegated to an intelligent inmate assistant. With proper training and supervision he can be taught to remove subgingival calculus and polish teeth in a satisfactory manner.

To many inmates the prophylaxis serves as an introduction to the dentist and dental care for the first time. First impressions of dentistry will be made at this time. It is therefore most important that the proper attitude is left with the patient if future cooperation is desired. If the work is done effectively and efficiently the inmate feels confident and pleased that his mouth is left with a clean refreshing taste that he probably never experienced before or ever thought possible. From this he looks forward anxiously to further treatment. A prophylaxis is given at least once a year, at which time the mouth is re-examined.

Oral Surgery: After prophylaxis, all surgery the mouth requires is performed. The removal of retained infected roots,

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cysts, very loose teeth in the advanced stages of periodontoclasia, etc. is prerequisite to any restorative work that is planned. Roentgenograms, at this time, are particularly helpful in locating and defining pathology.

As a rule, inmates cooperate readily in having the required surgery done, especially if there is pain and discomfort associated with the pathology. However, it may be difficult to convince them of the rationale of such treatment if they harbor a relatively symptomless, low-grade infection of long standing. Many prefer to omit this phase of treatment, but desire to have the necessary operative and prosthetic work done. It can not be stressed too much that the operator should never cater to an inmate in this respect, as the inmate is not competent to judge what is best for himself. Moreover, a patient's request for surgery must be carefully considered before such treatment is rendered.

In the course of systemic illness, such as a severe cold or gripe with marked constitutional symptoms, the teeth may become quite painful. On such occasions some inmates are known to demand that some or all of their teeth be extracted for the relief of pain. Obviously, such a radical procedure would be deeply regretted later by both the dentist and the patient.

The operator must also be aware of the patient who may have been a drug addict. Being denied this "escape" in prison, he is sometimes willing to sacrifice a tooth for the doubtful ecstasy of a procaine hypodermic.

Then too, there are some psychoneurotic personalities addicted to a condition known as "polysurgery." They derive an inner satisfaction from submitting to all sorts of surgical intervention for their real or imagined ills. It is a socially accepted manner of venting one's masochistic tendencies and provides a rich source of gossip and attention in the company of others.

Under no conditions should a dentist do surgery at an inmate's request unless there is a justifiable cause. Such therapy is otherwise detrimental and futile. A common notion existing among inmates is that teeth, if extracted, will be re-

placed. A patient entertaining such ideas must be informed, before any surgery is done, that he may or may not receive a replacement subject to the conditions outlined before. An understanding reached at this time will save much disappointment.

There seems little doubt that the oral surgeon has a major influence in neuropsychiatric treatment, but exactly what part and how important a role oral focal infection plays in neurologic and psychiatric disorders is difficult to evaluate. Unfortunately, there still exists much controversy and misconception as to what these factors are in both the medical as well as the dental profession.

As early as 1544, Ryff stated that violent pains in the teeth may cause syncope or epilepsy through injury communicated to the heart and brain. In 1750, Tissot described a serious nervous condition which may accompany eruption of the 3rd molars; and in 1803 Rush associated infected teeth with insanity. He said: "Irritation from certain foreign matters retained in irritable parts of the body is among the causes of insanity. It has been brought on in one instance by decayed teeth which were not accompanied by pain." The same author cites cases of headache, epilepsy, and vertigo cured by extractions. About 1915, following the work of Rosenow, the theory of focal or metastatic infection received new impetus; and as late as 1940, many writers still attributed a host of "algias" and "itis" of every conceivable organ in the human body, as well as a variety of mental conditions such as occasional neuroses and psychoses, to focal infections of oral origin. Not so long ago this idea was so popular that even the public willingly resorted to the wholesale removal of teeth, tonsils, and gall bladders in the firm belief that their obscure pains would disappear. However, the results of such measures too often never attained the benefits that were hoped for or expected. Recently the wisdom of such procedures has been strongly challenged. Many competent authorities today claim that the theories of focal infection are not based on sound scientific evidence, and show

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that there is very little proof to validate these beliefs any longer.

That an oral focus of infection can pollute the blood stream with micro-organisms and toxins, which might set up secondary manifestations in some other part of the body, is not questioned. However, we are not justified in claiming that a neuritis or an arthritis has resulted from such a focus. We must not be deluded into thinking that any beneficial effect that might occur following the removal of a focus of infection indicates that the improvement resulted from its elimination. On the other hand, failure to effect a cure does not mean that the oral focus could not have been the original cause.

Oral infections are often attended by neuritic or neuralgic pains that are reflected back along a nerve path to other structures about the head and neck, but such conditions have never been shown to be an infectious process in the nerves. Moreover, we must first rule out the possible psychogenic origin of these pains before attempting to establish a causal relationship with the infection. There is always the possibility that the mere interest and personal attention shown these patients was an important factor in their "cure."

Undoubtedly, a focus of infection, oral or otherwise, should be eliminated. Although we often see patients with septic mouth conditions who are apparently normal and in good health, chronic abscesses, purulent periodontal pockets, etc. constitute vicious factors that constantly sap the energy and vitality of the individual. If present to a great degree, it is not uncommon to find the patient suffering with general ill health, malaise, and systemic debility. Therefore, as a definite health measure, such foci must be removed.

However, one should not expect to cure an arthritis, a neuritis, a neurasthenia, a neurosis, a psychosis merely by removing a focus of infection. Too many patients seek relief from these disorders in a dental chair. Such complaints are common with inmates who have more time to brood over them and aggravate them; but no miraculous cures should be anticipated or promised to them.

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All surgery is done under local procaine anesthesia. In some cases, pre-operative sedation with the barbiturates may be prescribed to help relieve apprehension in the nervous hypertensive individual. This will also reduce the probability of fainting in those patients who are easily subject to syncope at the sight or thought of a hypodermic. Should rare occasions arise when a general anesthetic is desired, it should not be administered without competent professional assistance.

The post-operative care of inmates is a minor problem to the prison dentist. The regular habits of institutional life that the inmate leads is of great help to the surgeon in that it makes for a high level of resistance and recuperative power in the individual. With strict adherence to surgical principles and routine care, complications are rare and the incidence of post-operative treatment is low. The surgeon should not hesitate to grant a "lay-in" or "quarters" to surgical cases with excessive trauma or, if necessary, to hospitalize them for bed rest and hospital care. The hospital is also readily available for those who may develop severe complications. When systemic therapy is indicated, consultation and collaboration with the medical staff will be of great aid.

In connection with the "lay-in" or any sedative treatment that might be prescribed for the patient, one must be aware of the malingerer who feigns dental troubles in order to secure such consideration with a definite purpose in mind. Malingerer is a problem that does not ordinarily confront the dental officer. The inmate who wishes to pretend illness rarely gives dental symptoms to gain his ends. He would rather create symptoms, in another part of his anatomy, which are more difficult to diagnose and require more time and effort in investigation and treatment. However, to gain some immediate objective, an inmate may present himself at the dental clinic with an emergency complaint.

The common symptoms given by the malinger, the immediate objectives in mind and the usual "cures," are listed below:

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SYMPTOM	OBJECTIVE	CURE
1. Toothache	a. a lay-in b. aspirin tablets	a. Suggest that the tooth be extracted. b. Have inmate swallow dose in presence of dentist.
2. Headache or other neuralgia	a. a lay-in b. aspirin tablets	a. Same as 1-a or that other surgery be done. b. Same as 1-b.
3. Bleeding gums	a. Special dentifrice or mouthwash. b. Early consideration for a full dentures	a. Prescribe routine saline or epsom salt mouthwash. b. Check mouth for cause and institute appropriate therapy.
4. Stomach upsets	a. Full dentures b. Partial dentures	a. Reassure edentulous patient that service will be given as soon as possible. b. Decide definitely whether inmate has sufficient dentition for mastication or is entitled to a partial.

[For a much more detailed and thorough analysis of this problem the reader is referred to the article on malingering.]

Operative: Operative work follows the completion of all surgery. For this type of service all the familiar materials of the dentist's armamentarium are suitable for restorations: Silver and Copper amalgam, synthetic porcelain, Zinc oxide and Zinc oxyphosphate cements, etc.

In accordance with the principles outlined previously, time spent on operative procedures must be utilized most effectively by doing first things first. Hence, aside from variations that may arise, molar and cuspid restorations are given first consideration. This is obviously done to insure early preservation of abutments for future fixed or removable appliances. Then the other anteriors are cared for, and finally the buccuspids and

third molars. It is also wise to restore a tooth that is in occlusion before one that is not.

The use of precious metal gold alloys in penal dentistry is not a necessary or justified procedure. Of course, this precludes the possibilities of doing fixed crown and bridgework or inlays; but this type of service is highly elective and specialized in nature, and does not accomplish any more from the standpoint of physical health than the other materials do. Moreover, the expense of using such precious metals and the additional time that would have to be devoted to the production of inlays and bridgework would constitute an injustice to other beneficiaries. Doing such special work for a few patients would immediately decrease the time that could and should be spent treating others; or else it would require much additional personnel to cope with the problem. Perhaps with the recent development of acrylics and their perfection for inlay and bridgework, the problem of expense and time involved may be successfully resolved in the future. This type of service could then be made available to the inmate patient; at least under certain selected conditions. At present, should the dental officer be confronted with a situation that obviously calls for a crown or inlay restoration, temporary fillings of cement or alloy will adequately protect the pulp of a tooth until such a time when the patient is released and can have that type of service done by the private practitioner. Because of the time involved and the questionable results obtained, root canal therapy has never attained too prominent a place in penal dentistry. However, it has been the author's experience that in selected cases restricted to single-rooted anterior teeth, gratifying results can be obtained with the development of a proper aseptic technique. Much time is actually saved by not removing such anteriors and replacing them with an appliance. Moreover, the psychic effect of retaining his front teeth is strongly satisfactory to the inmate.

If time permits after all operative work is completed, fillings should be carefully polished. Not only does this prolong the life of the filling and enhance its appearance, but a job

well done is a source of great satisfaction to the operator and makes for a greater sense of appreciation on the part of the patient.

Prosthesis: No other branch of the prosthetic arts can boast of the high degree of efficiency and beauty to which its replacements have been carried as those of the dental profession. This achievement has come about only through years of intensive study in response to demands of mankind for the correction of crippling oral defects. Not only does this type of service provide the patient with an efficient functioning masticatory apparatus in part or as a whole but, perhaps more than any other branch of health care, it is associated with high esthetic value in the mind of the individual. Here again, prosthetic service to the inmate patient must be rendered primarily from the standpoint of physical health and secondarily from the cosmetic viewpoint. But it must be admitted that while a full or partial denture is provided for the practical mastication of food, an esthetic defect has also been removed with a strong psychic and emotional reaction.

When proper mastication of food is impossible due to an insufficient number of occluding teeth, the full or partial denture is a routine service because of the threat that such a condition poses to the health of the patient. Improper or incomplete mastication of food eventually gives rise to serious digestive disturbances which, when persisting over a period of time, are capable of producing mental traits of nervousness and irritability. It will be found that the full denture will usually meet most of the requirements for conditions found in the mouths of inmates. Moreover, it is the appliance of first choice because it can be made more quickly, at less expense, and in greater quantity. However, there are cases where the partial denture is indicated, and except for cosmetic considerations, it is furnished for utilitarian rather than esthetic purposes. Such appliances can be made very economically and satisfactorily with stainless steel or chrome alloy metals in the form of clasp wire, clasp blanks, lingual and palatal bars. After the problems involved in the physical health of the inmate are overcome we

can turn to the problem of cosmetic oral rehabilitation in order to improve facial harmony and appearance. This directly concerns the mental well being of the inmate and consequently his social rehabilitation which is, indeed, an important obligation. The most prominent feature of this type of service is the partial denture for the replacement of missing anterior teeth, a fairly common condition existing in an inmate population. To the sensitive individual such a defect not only represents an unsightly condition which by all means should be rectified, but also a physical deformity which is accompanied by strong emotional reactions. Here is a realistic situation like "buck teeth," protruding mandible, and cleft lip, which can be as profoundly moving as the hunch back or the club foot, and the matter is considerably aggravated in the mind of the afflicted with such ridiculing names as "snag" etc.

Though the individual with such a facial disfigurement may try to repress the unpleasant thoughts connected with it in an attempt to erase them from his consciousness, it does not necessarily put an end to his unfilled wishes to be like others and not to be "different." It is such repressed desires associated with disagreeable feelings that, according to psychoanalytic theory, constitute the so-called "complex" which is constantly striving for conscious expression. These complexes are responsible for much unhappiness and inefficiency in "normal individuals" and give rise to many functional disorders that are classed as psychoneuroses. As a rule, these are inferiority complexes coupled with abnormal facial expressions, poor speech, lack of spirit, and restraint from social contact. However, this is not universally true because often the mind succeeds in over-compensating for such a physical defect, and the result may be a socially stable individual, or one with a superiority complex. Among the latter group there are those who have become socially and economically successful, but there are also many who have found superiority by bullying a weak neighbor or by committing an antisocial act to "show-off." These can very well be the ones who eventually find themselves as inmates of a penal institution.

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All this, of course, does not mean that every inferiority or superiority complex stems from missing anterior teeth or any other gross defect of the mouth; nor does it indicate that with the construction of a partial denture or other operation about the oral cavity these complexes will disappear. However, there is sufficient "case history" in the literature to indicate that a gross dental defect with strong esthetic influences, along with other unhealthy environmental conditions, can be the major cause of such complexes or a strong contributing factor. It might even be far fetched to say that an individual may commit a crime because of a dental disfigurement, but there is justification for the belief that such a defect can be an important factor in certain reactions which might eventually find expression in a social offense.

It is therefore dentistry's grave responsibility to help the orally disabled individual from developing these unhealthy and abnormal personality traits, and where they do exist to do everything within its scope to help correct them by removing or ameliorating any defect that might be a contributing factor. In the management of the edentulous patient, it is customary to place a man on "soft diet" for about thirty-days. Soft diet is merely regular prison fare mechanically masticated for the patient by passing it through a food grinder. Unfortunately, this procedure is too often abused by the inmate with attempts to seek special soft foods; and the many complaints of digestive upsets, in spite of such preparation, seems to minimize the efficacy of this regimen. No doubt the unpleasant appearance of food presented in this manner with its accompanying psychic reactions, plus the fact that the patient will tend to gulp such food quickly, leads to these digestive disorders. It has been the writer's experience that these patients are less troublesome and more easily managed if simply allowed to do the best they can on the "main line." No doubt they eat much less than ordinarily for the first few days until soreness disappears, but on the whole they feel much better and readily become adjusted to "gumming" the food. In extreme cases a

soft diet can be prescribed for several days.

The educational and vocational training programs sponsored by Federal penal institutions are well integrated phases of the program of rehabilitation. They attempt to teach the illiterate to read and write, stimulate others to seek higher education, and train men to acquire skill in some productive occupation that can provide economic security after release. They foster a feeling of responsibility for holding a job and doing that job well. However, the success of these ambitious plans can be seriously jeopardized if, due to unsightly dentition, one is unable to face his fellowman and ask for a job. The high purpose of such programs would be void if a disfiguring oral condition immediately disqualified a man in the eyes of a prospective employer. Moreover, we must realize and appreciate the valuable contributions towards the achievement of these programs that a competent dental service makes when it copes with oral conditions that might arise to threaten their success.

It cannot be expected of an individual to keep interest in his work or maintain his efficiency when he is constantly plagued by oral pain and discomfort. The one who is frequently incapacitated because of a low state of general health attributable to mouth conditions, or the one who can not do his best because he is mentally retarded and physically debilitated by a chronic neuralgia or arthritis of dental origin, will not long remain a fit subject for such training. There are no doubts concerning dentistry's contribution towards a better and more capable individual. The interdependence of oral health and individual productiveness and ability is perhaps more recognized today than ever before. Oral sepsis, either of itself or as an underlying cause of systemic illness, is responsible for a staggering loss of effective manpower. Sooner or later, almost every offender reaches the termination of his sentence; his day to "get up" and return to society. He has paid his debt for the offense he committed, but society has also paid its debt to him in attempting to make of him a better man than he was previously. For the dentist, it should be heartening to know that he has done his vital share in giving this man the best .

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possible basis of physical and mental health; that he has helped to rehabilitate the criminal; that he has played a unique role in the drama of social protection.

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A VENEREAL DISEASE PROGRAM IN PRISON

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An adequate venereal disease program is especially important in prison both because of the close contact between individuals and the fact that the incidence of infection is greater than it is in the general population. It is important to the individual because it affects his rehabilitation in prison, his ability to get and to hold a job, and to assume normal family relations upon his release. It is also important to society that these men when released be either cured or rendered non-infectious.

Because of the immense scope of the venereal disease program, of necessity only a general summary of the problems and the way they are handled in prison can be given in a paper of this type. The effective venereal disease program begins the moment the individual arrives in prison. An immediate examination and questioning relative to the presence of venereal disease is imperative, so that precautions may be taken to prevent contagious patients from contact with others. This quarantine may be accomplished by immediate transfer to the prison hospital where quarantine precautions are taken. The promptness with which the segregation is accomplished means much towards the morale of the non-infectious person and impresses on the infected individual that the venereal disease program is actively concerned with his particular problem. Because syphilis is the most serious problem and presents the most time-consuming portion of the program we will consider it first.

Individuals with open lesions are, of course, most contagious. Material from suspected primary or secondary lesions is placed in a capillary tube, sealed, and sent to the laboratory for diagnosis. Dark field examinations done by anyone other than persons thoroughly trained and accustomed to such examinations are seldom satisfactory.

Blood tests are taken as soon as possible after entrance to the institution. Blood is preferably drawn in the morning before breakfast to obviate the false positive and doubtful reactions that sometimes occur after the ingestion of food. If possible, blood tests should be taken before the routine immunization for typhoid and smallpox. Smallpox vaccination, especially, has been shown to be the cause of frequent false positive reactions. For routine use, simple qualitative tests such as the Kahn, Kolmer, Kline, or Eagle is adequate. In a case of questionable serological report which is not explained by the history and examination of the patient, repeated quantitative serologies are helpful. A dependable, accessible, and accurate laboratory is an essential portion of any venereal disease program. Unless the laboratory returns are consistent, the physician loses confidence in the reports, and the subsequent doubt as to their validity is usually somehow transmitted to the patient. Unless the reports are returned promptly, infected persons may not be promptly segregated and treated. As a rule, it is better to take advantage of an established State or Federal laboratory, rather than to attempt to do the work in the institution itself. The results are usually more accurate where many tests are done, both because of the experience of the personnel and the freshness of the antigen material. Furthermore, the inmate feels more confidence in a laboratory which is impersonal, and the possibility of bribing or putting undue pressure upon the laboratory force is also avoided. Frequently patients have no symptoms and are first made aware of their syphilis following the blood test upon admission to the institution. Unless the laboratory is trusted, there is a possibility that the inmate will feel that the whole diagnosis is a mistake and the treatment is one of the arbitrary discomforts forced upon him.

An interview with a syphilitic patient should take place before definitive treatment is started. The atmosphere of this interview may determine whether the patient willingly and conscientiously takes treatment, or avails himself of every opportunity to miss it. The interview before treatment gives the patient the feeling that he is personally being treated for his

disease and that he is not just another "con" being subjected to an unpleasant or uncomfortable compulsory routine procedure. Emphasis is placed upon the personal factor and each case is treated on its individual merits. The patient is told the advantages of treatment for his own health as well as to his family, his ability to get and hold a job at the time of his release, and his selection for preferential jobs in the institution. He is told of the possible complications when adequate treatment is not given, so that if he is released before the completion of treatment, he will know why he should continue therapy. Many of these individuals who have known of their infection have had rather haphazard treatment. That, in part, is due to their nomadic way of life, their irresponsible nature, or in some cases to poor advice on the part of physicians. Especially is the latter true in those cases treated some few years ago when rest periods were much more common and the amount of arsenical administered was much less.

We have found it helpful to study the statistical possibilities for cure so that an individual can be told approximately what his chance is of becoming cured under the program outlined for him. This is a morale building factor which encourages the individual to continue the treatment when he is released.

The problem of locating contacts, in Federal prisons at least, is very difficult. The problem posed in the notification of an inmate's wife and the family is similarly a very difficult one. The individual is separated from his family without being able to talk with them personally. He has just been sent to prison and this tends to estrange him from his family. Unless the situation is diplomatically handled, the added impact of being told that he has syphilis may precipitate divorce, or the **breaking up of the home**. At times it seems best to allow the individual to inform his family by letter if he so desires, or at the time of a visit if the infection is in such a stage that a few weeks delay will not endanger the health of the individuals concerned.

Complete data as to the number of children, health of the

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marital partner, presence of miscarriage or abnormal births, often help to date the time of initial infection if it is not already known. Also helpful is the date of the last previous negative blood test, either on a Selective Service examination, previous hospitalization, marriage license, industrial examination, or similar type of examination. For those previously treated a record is obtained of the time of the infection, previous blood tests or spinal fluid findings, previous treatment and reactions to such treatment. Patients tend to exaggerate the amount of treatment they have received in the hope that less will be required of them in the institution. The records from doctors, hospitals and institutions previously treating the patient are the only accurate index of the kind and amount of treatment received.

A physical examination should be done at the time of the original interview. Emphasis is placed on the common neurological tests, examination of the heart, eyes, and skin. A tentative diagnosis is then made of the type of syphilis encountered. Suspected aortitis or cardiac involvement is further checked with fluoroscopy and electrocardiograms; while suspected central nervous system involvement is investigated with spinal fluid examination.

Any treatment prescribed must take into account the age of the individual, duration of the syphilis and complication of the disease, as well as the general physical condition of the patient. So far penicillin has not been available for routine treatment in prisons. Experimental reports are encouraging, but as yet not enough patients have been treated, nor have those treated been followed for a sufficient length of time, to make a final evaluation of the drug possible.

In conformity with United States Public Health Service and cooperative clinical group recommendations, the accepted treatment at present utilizes the arsenical drugs, especially mapharsen, neoarsphenamine, and tryparsamide combined with bismuth usually in oil suspension.

In general, the rapidity of treatment and its intensity in

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prison should be that which is consistent with the special situation existing there. The individual and the public health must both be considered before deciding on the exact method of therapy. The local or county prisons where individuals are first incarcerated, and where primary or secondary syphilis is seen more commonly, should ideally use a more intensive type of therapy than Federal or State institutions. When an individual is required to submit to treatment, that treatment should endanger life as little as possible. Eagle and his associates have shown that in man a curative dose of arsenic and bismuth is essentially the same, but that shortening the time interval with which it is given increases mortality rates. For example, 1200 mg. of mapharsen given by weekly injection of 60 mg each results in a mortality of about one in five thousand or less. The same amount given in five or six days results in a mortality rate of about one in two hundred. Therefore, the length of time an individual is to be incarcerated may enter into the type of treatment given. An individual with a short sentence who would tend to lapse treatment once he is released should be given more intensive treatment than an individual who is genuinely interested in becoming cured, or an individual with a long sentence.

In general, as has been said, the type of treatment given is that recommended by the cooperative clinics and the United States Public Health Service. Primary and secondary cases should be started on mapharsen immediately. Early and late latent cases should have weekly injections of bismuth alone for six to ten weeks to prevent Herzheimer type reactions. Some individuals tolerate neoarsphenamine better than mapharsen, although as a rule mapharsen is the drug of choice. One 30 mg. dose of mapharsen should be given initially to determine possible sensitivity to the drug. Primary, secondary and early latent cases can be given mapharsen in 60 mg. doses once, twice, or three times a week combined with one c.c. of bismuth subsalicylate once a week, depending upon the age, general health and reaction to the drugs. This can be continued until twenty arsenical injections and twenty bismuth injections have

been given. Following this, the arsenicals and bismuth can be alternated in courses from eight to twelve injections to a course as long as it is deemed necessary. It is preferable to finish the treatment with bismuth.

Late latent cases are best treated less intensively. Weekly bismuth injections are given for at least ten weeks, followed by alternating courses of eight to twelve injections of mapharsen and bismuth. Potassium iodide is given in five grain doses three times a day, and may accompany the bismuth injections unless unfavorable reactions are present. At least twenty arsenical and twenty bismuth injections are given. In most cases, more than this amount is advisable. Reactions to this type of treatment are infrequent if patients are carefully watched. The gastro-intestinal disturbances are usually mild and do not require interruption of treatment. Occasionally, expoliative dermatitis will occur. If promptly recognized and treated, this will usually respond readily to treatment. Either a "bismuth line" or gingivitis can best be prevented and treated with proper oral hygiene. With frequent urine examinations, early manifestations of kidney damage can be recognized promptly and severe damage prevented.

The visceral manifestations of syphilis tend to vary with the age group treated. As has been mentioned before, irregular or inadequate treatment is more common in the group coming to prison, and therefore the incidence of complications of syphilis is somewhat higher. Spinal fluid examinations are urged for all persons with positive blood tests. Because individuals with spinal involvement are no more infectious to other inmates than those with positive serology alone, spinals are not made compulsory. Inmates with syphilis are not given jobs involving the use of machinery, positions of special trust, or positions where other individuals' lives are endangered by their judgment unless they submit to a spinal fluid examination. In prison we have found that individuals are much more agreeable to spinal punctures, and post-spinal headaches less common, if they are given a twenty-four hour rest period following the puncture.

Treatment of neuro-syphilis depends upon the type of nervous system involvement and its activity. If possible, a preliminary course of mapharsen and bismuth seems advisable. Where there is active meningo-vascular syphilis, these drugs are best continued for a longer time. Tryparsamide is the drug of choice in paresis, taboparesis and, following mapharsen, in any nervous system involvements. Visual fields and eye-ground examinations should be checked carefully before tryparsamide therapy is instituted and periodically every four weeks during treatment. If no eye-ground or visual field changes are manifest, tryparsamide may be given weekly for at least a year without any rest period. Bismuth should be given concurrently in courses of eight to twelve injections weekly.

Moore, in his monograph, *The Modern Treatment of Syphilis*, comments as follows about the use of fever: "Paresis, taboparesis, and primary optic atrophy are imperative indications for the use of fever therapy. The results are so much better than with any other form of treatment that to postpone fever in the favor of a trial of another method is to invite progressive deterioration and death or blindness." With any other central nervous system involvement, after a period of chemotherapy, fever therapy is indicated if the desired results have not been obtained.

The method of inducing fever therapy will depend upon the type of fever available and the familiarity of the physician with the technique used. Malaria, while not as easily controlled, and not applicable to all patients, has the advantage of requiring less specialized equipment and less specialized technical knowledge. Regardless of the type of fever used, it should be followed by chemotherapy.

Cardiovascular syphilis is always treated conservatively. Patients in failure are given only potassium iodide until that failure is corrected. All cardiovascular syphilis should be treated with potassium iodide and bismuth before any type of arsenical is used. Only in those cases of moderate or mild involvement does arsenical therapy seem indicated and then

mapharsen, beginning with small doses, is the drug of choice. Further treatment consists of bismuth and potassium iodide with alternate courses of mapharsen which should be maintained for at least two years with as little rest as possible. The other rare but multitudinous manifestations of visceral syphilis are treated as indications arise.

The actual set-up of the treatment line is important. The time treatment is given will vary with the general program of the institution. For the convenience of the personnel, treatments are best given *en masse* twice or three times a week. Mild gastro-intestinal reactions are fewer, if the arsenicals are given on an empty stomach. The general morale is improved if patients can be excused from strenuous physical activity for a few hours after their treatment.

Where inmate help is utilized for clerical work or record keeping, a system of checks to prevent individuals from skipping treatment is usually necessary. If possible, a double checking system is preferred to avoid mistakes, or to prevent one checker from being bribed. The actual preparation and administration of the drugs must be in professional hands at all times.

At the end of each course of treatment the individual has a repeat blood test, is interviewed and examined again for any signs of the disease. This interview with the patient again emphasizes the fact that he is being treated as an individual, and has not just been put on the "shot-line" and forgotten.

Urinalysis and weight determinations are made once a month to recognize the incipient adverse reactions to treatment. With patients under constant observation, as is possible in a prison set-up, early reactions to the various drugs are more easily recognized and serious reactions prevented.

The usually accepted type of follow-up is used after the patient is relieved from active treatment. Blood tests are repeated periodically in gradually lengthening periods, starting with one month, and lengthening to once every six months. Complete physical examinations are done at the time of each

blood test. Spinal punctures are strongly recommended before a patient is released from treatment.

When such individuals under treatment or observation are to be released from the institution, they are advised to place themselves in the care of a clinic or private physician for observation and further treatment, if necessary. For those individuals under treatment at the time of their release, probation officers should be informed of the necessity for further treatment and advised to check that it is received. Records of the treatment in prison are readily available to any physician making the request.

Advice as to the possibility of infection or contagion to the family is frequently requested. Of course, each individual case is different, but, in general, the necessity for remaining on treatment is emphasized, and the suggested period of possibility for infection is the longest rather than the shortest commonly accepted.

In summary, emphasis in the treatment of syphilis in prison is immediate recognition of the affected individual, proper segregation, individualized treatment of the most intensive type consistent with safety, and careful observation for complications and reactions.

Gonorrhea and its complications are frequently encountered in prison practice. As with syphilis, the immediate diagnosis and proper segregation of the infected individual is an essential portion of any program. Active, acute gonorrhea is more frequently found in the smaller institutions where prisoners are first received than in the larger institutions where prisoners are serving longer sentences. Because of the nature of the disease, an individual may show no evidence of the disease on admission and later a focus of infection will flare up or show definite activity. This is always a possible source of infection. Because of the incidence of homosexual activity in prison, the possibility of gonorrheal proctitis should always be given consideration. With the type of treatment now available, and the conscientious use of smears and culture following

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treatment, the number of recurrences can be kept to a minimum. The recent reports as to the use of penicillin suggest that it may be the accepted type of treatment when it becomes available in sufficient quantities. Until then, the sulfa drugs will be quite effective.

The usually accepted method of administration is to give sulfathiazole in doses of one gram combined with an equal amount of sodium bicarbonate four times a day for five days. Following the completion of this treatment, if gonococci are still present the course is repeated using sulfadiazine in place of sulfathiazole.

With careful alkalinization of the urine and insistence on blood counts before and during treatment, the more serious reactions to the sulfa drugs can be avoided.

Individuals who were infected originally when the common mode of treatment included silver injections, potassium permanganate irrigations, and frequent sounds, tend to have more strictures and chronically infected prostates. When these individuals acquire a new gonorrheal infection, they usually require the correction of the strictures, and prostatic massages, in addition to the routine therapy. In general, traumatic or congenital abnormalities of the penis or urethra also require correction before the infection can be cured.

In the prison system we have found it advantageous to hospitalize gonorrhea patients where they can be properly isolated, their medications supervised, blood studies and urines followed, and fluid intake controlled. We believe that fewer complications result with bed rest and limited activity than on unrestricted activity. Patients may be discharged after negative cultures and smears, and kept on moderate activity until weekly rechecks of activities and smears are reported negative for one month.

As with syphilis, the notification of the marital partners presents a delicate situation. When there is a possibility of the patient himself notifying the partner, he should be the one to do it; otherwise the partner should be notified and advised to have the necessary examinations.

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The complications of gonorrhea such as epididymitis, arthritis, conjunctivitis, and seminal vesiculitis are fortunately comparatively rare, but are treated with the usual procedure when they are encountered. Drug reactions are also uncommon. Renal complications are largely prevented with alkalization of the urine, and skin manifestations as seen here have not been severe. Gastro-intestinal reactions, as a rule, do not interfere with therapy.

The other less common venereal diseases such as chancroid, granuloma inguinale, and lympho-granuloma inguinale are treated with the same general principles of immediate segregation and specific therapy. Venereal warts are not uncommonly seen, and when situated around the anus pose a differential diagnosis from condyloma acuminata. They are usually treated by electric dessication, but surgical cautery excision may be required.

Because of the active research program pertaining to venereal disease and its therapy, the accepted types of treatment which are used today may be out-moded several months or years from now. The basic principles of segregation, individualized treatment, careful, conscientious observation of the patient for adverse reactions to drugs, and prolonged observation for relapse or recurrence of the infection will, however, remain.

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THE PSYCHIATRIC ASPECTS OF MALINGERING

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Most laymen and many doctors regard malingering as a drastic, melodramatic, clinical entity. They think of the soldier who shoots himself in the foot in order to be discharged from the army, or of the prisoner who cuts his achilles tendon in order to avoid the rigors of prison life. However, such examples of malingering are not frequent in prisons, although they are occasionally encountered. The diagnosis of malingering is not often made, yet there is a great deal of malingering in prisons.

One definition of malingering, as good as any, can be taken from Funk and Wagnall's *College Standard Dictionary*. This definition reads: "To feign sickness or inability." It is significant to realize that the definition is qualitative rather than quantitative. To feign a headache is as much malingering as to feign a brain tumor. It is this dramatic type of malingering that is often encountered in prisons, and which is very difficult to treat. For every man who complains of serious illness, there are a hundred who come to the hospital with minor complaints and who are seeking to use the hospital as a tool in obtaining some minor or major objective.

These minor complaints are rarely diagnosed officially as malingering, yet they are nothing else. They take up a great part of the doctor's time, and they result in the loss of many man-hours in the institution work schedule. It is the object of this paper to illustrate some of the types of petty malingering and to discuss means for their diagnosis and treatment.

Although any inmate may malingering at some time, the most frequent of such offenders are the psychopaths. They are cool, anti-social and egoistic. They feel that the world owes them a living and they have no intention of doing any more work than is absolutely necessary. Consequently, they

devise scheme after scheme to avoid work, and they find the hospital a convenient place to put many of these schemes into practice. Evasion of work is not the only reason for feigning disability. Many objectives can be reached through successful malingering, and several are listed below:

1. To get special concessions.
2. To avoid work for a day or two.
3. To avoid work during the last day or two in the institution.
4. To get a medical history on which to base a future request for change of assignment.
5. To aid in obtaining parole or other type of early release.
6. To use the hospital as a place of refuge.
7. To test a new doctor.
8. To give a message to an inmate in the hospital.
9. To attack an inmate already in the hospital.
10. To establish homosexual contacts in the hospital.
11. Attention getting.

This list is arranged roughly in order of decreasing frequency, according to the opinion of the author. There are no statistical studies available. The following list gives some of the more common symptoms encountered in the malingerer:

1. Headache.
2. Stomach ache.
3. Backache.
4. Heart trouble.
5. Sore feet.
7. Belt hurts stomach.
7. Pain in chest.
8. Asthma.
9. Tuberculosis—Smoking a cigarette with iodine in it just before X-ray, or changing sputum cups with a real tubercular, has been noted.
10. Insomnia.

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11. Anorexia.
12. Nausea—Used especially to avoid mapharsen injections.
13. Sore hip—Used mainly to avoid bismuth injections.
14. Dizzy spells—A rare malingerer symptom, usually seen in the hysterical and psychoneurotic.

The commonest reason for malingering in prison is to get some minor concession. Due to the monotony of prison routine where everyone arises at the same time as every one else, every day, eats the same food as everyone else, every day, and goes to bed at the same time as everyone else, every day, many inmates strive valiantly to be just a little different from their fellows. A special shoe shine, a specially bleached and pressed pair of trousers, a different belt or a pair of suspenders, a better pipe, a better handkerchief; all of these are means for an inmate to set himself apart from the others. Such favors, and many others, are procured from other inmates in a position to grant them, at the cost of a pack or a carton of cigarettes, or some other medium of exchange. The hospital is a favorite place to obtain some of these concessions, and malingering is the method least costly to the inmate. But, if this fails, the services can sometimes be bought from a hospital inmate orderly who is willing to sell, for instance, a pair of spectacles for a considerable profit. Some of the more frequently sought favors, obtained through the hospital, are special shoes, either orthopedic or merely the inmate's own shoes rather than the prison issue, suspenders instead of a belt, an extra-short haircut, partial dentures, and more frequent changes of clothing, especially socks. Complaints used to obtain these favors are obvious: "I've always had to have my shoes especially made, I can't wear these shoes, you know I want to work, but how can I in these shoes?"

"I have stomach trouble and I can't wear a belt, it hurts my stomach, my doctor told me never to wear a belt."

"My scalp itches, I have to get my hair cut short so I can treat my scalp."

"I can't eat unless I get my teeth fixed, I need a partial plate."

"My feet sweat all the time. I have to change socks twice a day."

Another type of favor sought is a change in work assignment. Some other job seems more desirable, often because in the desired job there are more chances for special distinctions. The complaints used for this purpose are legion and only a few can be described here. Men on labor details contend they suffer from chronic back-ache; inmates in the kitchen or laundry report constant colds or chest trouble due to the steam or moisture; those who want outdoor jobs complain of asthma indoors, and men who desire indoor work complain of asthma outdoors. The reason for the complaint is not usually given to the doctor first. The inmate comes to the hospital for treatment, describing his pains or discomfort. Frequently, he is hospitalized when out-patient treatment does not alleviate his alleged suffering. He may have a few wheezes in his chest, is diagnosed a mild asthmatic, and after a few days is discharged improved. A month or two later he may request a transfer, stating that his present job is bad for his asthma. An inquiry is sent to the medical department and the Chief Medical Officer, who may not have had an occasion to acquaint himself closely with the case when the man was hospitalized, looks over the record, finds the diagnosis of asthma, and recommends the transfer.

Sometimes the inmate attempts to use the hospital in an elaborate scheme to influence the Parole Board. Such schemes usually involve outside doctors and lawyers, and are not attempted by the average inmate because he cannot afford the cost of such assistance. The procedure is as follows: On admission to the institution the inmate brings letters from his family physician or from several physicians of some reputable hospital where he has been recently treated for some disability, for instance, diabetes. The letter gives in minute detail a strict diet the patient must follow, with dire warnings of the great danger to the man's health if the diet is not adhered to. Al-

though an adequate diabetic diet can be given in prison, it is almost never possible to follow precisely the routine outlined in the letter. The inmate soon begins to complain that he feels much worse and notifies his lawyer who puts pressure on the judge and Parole Board to obtain an early release. Usually these attempts are unproductive, for the hospital is always asked to send a report, and since the blood-sugar and glucose tolerance tests usually show that he is getting along perfectly well, this report effectively prevents successful conclusions of the elaborate scheme to obtain release from the institution. Usually the would-be diabetic has never taken any insulin, or has taken it in such small doses that he can hardly be considered a diabetic. Naturally, all diabetics entering an institution are not trying to trick the doctor. Some are concerned about their health and bring letters from their doctors as an aid in treating their diseases adequately.

Another use for the hospital is as a place of refuge, and any illness may be simulated if it will gain admission. The inmate who attempts this is one who has "ratted" on another, or has in some way antagonized another inmate. Frequently, the custodial department knows the facts and tells the doctor which inmate the malingerer fears. Diagnosis is complete if the other inmate gains admission to the hospital. The first inmate promptly "recovers," and clamors for release. Although seemingly trivial, such activity can never be regarded lightly, because infraction of the prison code by an inmate often brings swift and fatal punishment at the hands of the offended one. The doctor who has been at a prison a year or two will not usually be fooled by this type of malingering, but the new doctor may be deceived. If he does not discharge the malingerer promptly, he may find a serious surgical problem awaiting him the next day.

New doctors at an institution are always subjected to elaborate tests by the inmates, to learn how easily they can be fooled. The problem is not whether or not the new doctor can be fooled, but how easily it can be done. No doctor is able to spot the malingerer every time. He cannot do so if he is

a conscientious physician. He must assume that the sickness is real until he proves it otherwise, lest a dangerous illness result. Since medical science cannot always diagnose a series of vague symptoms even when they are real, some malingerers will receive the benefit of the doubt, and thus gain their objective. That is why the new doctor finds that he has many more puzzling illnesses to treat than the others, and he soon learns to differentiate in most cases.

A few inmates mangle merely to get attention, with no other goal in view. They are borderline neurotics, and are usually the weak-willed, easily influenced type of person. A few aspirin tablets or an occasional laxative usually satisfies their need. However, with these malingerers as with all others, the doctor must be on guard lest he miss a serious illness. For instance, an inmate was admitted to the hospital on the day of his admission to the institution with nausea and abdominal pains. He gave a history of similar pains at intervals for months. The pains started while he was in the army and a discharge was granted him because of them after detailed examination in army hospitals. After discharge, he was unable to keep a job because of the recurrent pain, yet frequent hospitalization resulted in no definite diagnosis. He was a young man, and the history was typical of the malingerer or hysteric who could not stand army life. Physical examination and blood count were normal, yet on the following day his abdomen became rigid and operation revealed a gangrenous appendix with many old adhesions. Recovery was uneventful. Too prompt a diagnosis of malingering could have been fatal.

A rare cause of malingering is encountered in the homosexual who attempts to gain admission to the hospital and establish sexual relations with his partner who happens to be in the hospital either as a patient or as an orderly. The hospital at night sometimes affords better opportunities for such practices than the cell-house or dormitory. Since most of the homosexuals are known, it is easy to spot this sort of scheme.

The management of malingering is not a simple matter in prison. In private practice, the doctor who is unable to re-

lieve his patient's suffering sends the patient to another doctor for advice. In prison, the inmates cannot go to another doctor: the problem has to be handled by the local hospital staff. Close cooperation between the hospital and the custodial staff is essential. Frequently a few words to the detail and cell-house officers of the complaining inmate reveals a clue. The "grapevine" must never be ignored. It can be of great aid, not only in diagnosing the malingerer, but in gaining information which will assist the doctor to be of genuine help to the inmate.

Not more than a few years ago, and possibly even today in some institutions, all inmates who came to the hospital were assumed to be malingering, unless they had an injury or disease so obvious that the layman could have diagnosed it. They were given treatment, the main objective of which was to discourage their return to the hospital. Routine prescription of large doses of castor oil or prostate massage for any complaint were administered whether indicated or not. Such practice certainly decreased the attendance on sick line or emergency call and gave the hospital staff plenty of time to do nothing. But, what is the use of having a medical department in prison if it has nothing to do? The health of the inmate suffers, his rehabilitation is retarded, and the hospital staff stagnates. It is much more logical as well as more befitting the standard of a physician to assume that all complaints are due to genuine illness, because many of them really are. A diagnosis of malingering should be given only after considerable time and study of each case. An outline for the management of the suspected malingerer is given below:

1. Assume that the patient is ill, obtain a brief history and if no definite illness can be diagnosed, treat symptomatically with mild medication such as aspirin, mild laxatives, anti-acid tablets or the like.
2. When the patient returns with the same complaint—the malingerer will—get a more detailed history and examine more carefully, including any indicated laboratory procedures that are available, such as blood count,

blood chemistry, X-ray, basal metabolism or electrocardiograph.

3. Eliminate the hysterical, neurotic and psychotic. If a psychiatrist is available, a consultation is advisable at this point.
4. Obtain information about the patient from all available sources including the cell-house officer, the detail officer, the lieutenant of the day and night watches, the disciplinary board, and the grapevine. If the information obtained via the grapevine cannot be used to help the patient, it is better to disregard it, assuming, of course, that no danger to the institution arises from doing so. Use of the grapevine which does not help the patient puts the informer in a dangerous position and damages the doctor's rapport with all of the inmates. He is of less value then as a physician than if he had ignored the information completely.
5. Regard the malingerer (for by now the diagnosis is fairly well established) as a psychiatric problem primarily, because he is using a nonrealistic means for reaching a goal.

Possibly the reader has noticed the absence of diagnostic "tricks" to determine malingering. There are a few which can safely be used, especially in diagnosing malingerers with optical complaints. The army has published a pamphlet very useful for such problems. However, in the author's experience, many of these tricks can be misleading. According to recognized authorities, pain is accompanied by dilated pupils and rapid pulse. Unfortunately, this is not always true, and one cannot rely upon it as a diagnostic aid. Another ruse, once used by the author for complaints of abdominal pain, was to press first the area indicated by the patient, who usually winced and tightened the abdomen. The pressure was then put on some other area where the inmate said there was no pain, while at the same time pressure was put on the supposedly tender area. If the patient did not wince, he was considered to be malingering. This practice was discontinued

after the author had proven to his own satisfaction that a man complaining of right upper quadrant pain was a malingerer, shortly before the surgeon operated and removed a gall bladder packed with stones.

During the diagnostic procedures outlined above many malingerers will give up, or attempt other means for reaching the goal. However, some will persist, and the management of these becomes a psychiatric problem. We are confronted by a group of men who are attempting to reach a goal by non-realistic, almost self-destructive means. Even though physical self-mutilation is rarely involved, mental self-mutilation is always present. No personality can maintain respect for itself when it is trying to prove that it is too weak to do the job.

If the malingering is successful it will be tried again under any situation of stress, and eventually the inmate, instead of being better able to face the problems he will encounter in society, will find adjustment an insuperable problem when he leaves the prison. It is to combat such degradation of personality that adequate psychiatric treatment of the malingerer is vitally important. The objections to this idea are obvious, and one can almost hear them. "Sure, it would be a fine idea to show these men how unrealistic they are, but you said that most malingerers are psychopaths who don't want to be helped, they are satisfied with themselves."

But are psychopaths satisfied with themselves? In the few cases when a fairly good rapport was established between the author and psychopaths, they admitted that they did not like to be always in trouble, that they would like to settle down to a normal quiet life, but that they just couldn't, and that they just did not know why they couldn't. Unfortunately, the author did not know why either and was not much help to them. But that does not mean we should stop trying to understand why; eventually we will find the answer and be able to help. However, this paper is not a discussion of methods of treating psychopaths; yet, we cannot escape the fact that treatment of malingering is, in the majority of cases, the treatment of psychopathy.

Psychiatric treatment varies greatly from one psychiatrist to the next. The larger hospitals have a full-time psychiatrist, but many small places have only one or two doctors, neither of whom have had prolonged psychiatric training. It is particularly for such instances that this outline may be of some value. The establishment of rapport between psychiatrist and patient is often difficult, and in prison it is especially so because the inmate identifies the doctor with the custodial staff and not only resents his questions but is usually afraid to answer them for fear of creating trouble for himself. The doctor is in a dilemma also, because the code of medical ethics which prohibits the doctor from revealing statements made to him in confidence applies in prison as well as outside. Yet, if he is told information about an intended prison break, he is obliged to notify the prison authorities. He is also handicapped by the fact that anything confidential revealed to him cannot be written down, since written facts may eventually be read by some inmate, and possibly used to the patient's disadvantage. Inmates know this, and will tell nothing confidential if they see the doctor taking notes. One way to allay this tendency to identify the doctor with the custodial staff is to explain to the patient that his confidence will be respected unless he reveals facts which relate to the safety of the institution, in which case the doctor will call the authorities, but will tell the inmate that he is going to do so at the same time.

The initial steps in the psychiatric examination and treatment of malingering are different from those used with patients who have come of their own accord to the psychiatrist for help. The malingerer has not consulted the psychiatrist willingly, and he is suspicious that the consultation is an attempt to show up his schemes to outwit the hospital staff. Under such conditions rapport between doctor and patient is clearly impossible—yet no help can be given the patient unless rapport is established. The following method will prove useful in many cases.

Assuming that the diagnosis of malingering has been established beyond question, the patient should be told that the

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doctors who examined him are convinced that he does not have the illness he claims to have, and that the psychiatrist believes he simulated the disease in order to achieve a definite goal. Usually it is possible to state what the goal seems to be, although if the goal is not clear it is better merely to say that it is realized the patient simulated for some purpose not entirely clear to the doctor. The psychiatrist must not call the man a malingerer, nor give the impression that the purpose of the interview is to announce the triumph of the hospital diagnostic procedures over the inmate and his schemes. The psychiatrist must explain that the interview has been arranged in order to learn why it was necessary for the inmate to attempt to deceive the doctor. It is necessary to discuss the inmate's work in the institution, his likes and dislikes, and his plans for the period after release. No rigid rules can be adhered to; the psychiatrist must feel his way here, and attempt to sell the idea that he has something of value to contribute to the inmate's way of life. It is better to let the patient do most of the talking, and then, toward the end of the interview, to suggest that the method used by the patient was not really a sensible one, that it was the way children attempt to evade work or gain their ends. The interview should end with a discussion of the patient's reason for malingering, although that word should not be used yet in the conversation. If there seems some justification in the goal which the patient attempted to reach by malingering, the psychiatrist should suggest a more logical means for reaching that goal. If the inmate tries, or has tried, such methods without success, and the doctor is convinced that the goal is beneficial to the man's personality or health, he should help him by explaining the problem to the custodial staff.

The next interview should follow as soon as possible—preferably the next day—and during this a brief family and personal history should be obtained, with emphasis on questions of importance in establishing the psychiatric background of the patient. It is necessary to know of any mental illness in the family, as far back as the patient recalls, including such things as hospitalization for psychosis, epilepsy, drug addiction,

alcoholism, eccentric relatives, and any other unusual personality characteristics. A brief mental status examination is advisable to test the patient's orientation, memory, and general mental characteristics. This should be done subtly, so that the patient does not get the impression that his sanity is being questioned. When the psychiatrist is convinced that he is not dealing with a psychotic he can continue the interview with emphasis on the realistic ways of accomplishing things in life, and the danger to the man's personality in evading realism and gaining ends by weakness.

There is no guarantee that this method will help everyone; in fact, there are many who will not be interested and will not attempt to change their attitude. However, a few will listen and think, and a very few will be helped in gaining a clearer understanding of their own personality, and in making a better adjustment. If the psychiatrist can help even these few, his time has not been wasted.

THE ROLE OF THE PSYCHIATRIST IN THE UNITED STATES DISCIPLINARY BARRACKS

EWIN S. CHAPPELL, M.D.

What is now known as the United States Disciplinary Barracks, Fort Leavenworth, Kansas, was first established as a military prison under the War Department in 1874 at the site of what was formerly a Quartermaster Depot. It has not been operated continuously as a military prison since its founding, but it has ordinarily been used as such during and for some years after periods of military emergency when the number of military offenders would be relatively large. When not in use as a military prison it has, as a rule, been operated by the Department of Justice as a United States Penitentiary or as a branch thereof. It is of interest to point out that the United States Penitentiary, Leavenworth, Kansas, which is and for many years has been operated under the Department of Justice, is an outgrowth of the military prison now known as the United States Disciplinary Barracks, and that much of the construction work on it was done by military prisoners who were marched from and then back to the military institution each working day.

The name of the military institution was changed from the United States Military Prison to the United States Disciplinary Barracks in 1915, and, at such times as it has been under War Department control, that has been its name since. It was last turned over to the War Department from the Department of Justice on December 16, 1940, and it has functioned as the United States Disciplinary Barracks without interruption since that time.

The United States Disciplinary Barracks is a maximum security institution with a normal capacity of about two thousand inmates, and its plant is constructed accordingly. The two main objectives of all of its activities are the rehabilitation and

the honorable restoration to the military service of all those inmates who demonstrate their fitness for further service, and the maximum rehabilitation of the remaining inmates so that after discharge they will be able to meet successfully the duties and obligations of good citizens.

These objectives are attained by a well-rounded rehabilitation program in which the inmates are, as soon as possible after arrival at the institution, given thorough medical, psychiatric, social, psychological, educational, vocational, and religious evaluations which determine the therapy needed, and in which the needed treatment is then given in the forms of physical rehabilitation, psychotherapy with a view toward the development of insight and proper orientation, discipline and military training, education, occupation, recreation, and spiritual welfare. Prisoners are accorded humane treatment without coddling. They are treated as if they were normal and adequately adjusted persons, insofar as this is possible, in the belief that in response to such treatment they will gradually tend to behave in a more normal or socially acceptable manner. Inmates receive the regular army field ration; they live in sanitary quarters and are required to maintain high standards of personal hygiene; they engage in constructive work activities; they are given educational and vocational training opportunities; they participate in a carefully planned recreation program; and they are encouraged to take part in the diversified religious program of the institution. In addition, those who are considered potentially suitable for further military service are given intensive training in military subjects in an organization which is known as a disciplinary company.

The enforcement of discipline throughout the institution is a function of all the duty personnel of the command, but institutional punishments, which are those given for relatively minor infractions, can be awarded and carried out only at the direction of the Commandant. It should be mentioned in passing that all inmates are subject to trial by court-martial for any of the more serious offenses which they may commit while in confinement.

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The Commandant is in command of the institution; all authority in the institution stems from him; and all military and civilian personnel assigned for duty there serve in an advisory or auxiliary capacity to him. As will be brought out in another section of this article, the psychiatrist functions principally in an advisory capacity to the Commandant and to his assistants in matters pertaining to his specialty.

The United States Disciplinary Barracks receives its inmates, who in almost all instances are general prisoners (a general prisoner is one who has been given an approved sentence by a general court-martial which carries with it a dishonorable discharge from the service), from various sources, the principal ones of which are rehabilitation centers, medium security disciplinary barracks, prisoner of war camps, federal institutions which have had military prisoners committed to their custody, and guardhouses or stockades. With the exception of former officers, warrant officers, flight officers, and convicted prisoners of war, only those prisoners who have for one reason or another been considered to be habitual offenders and incorrigibles, or who have been thought to be virtually irreclaimable for the service, are sent to the United States Disciplinary Barracks, this being in keeping with its function as a maximum security institution. It should be emphasized, however, that not all of the inmates turn out to be as irredeemable as they appeared at the time they were directed to be sent to the United States Disciplinary Barracks, and that still others improve in response to the rehabilitation program of the institution, so that the gloomy view that it is dealing with virtually hopeless cases is not to be entertained. The United States Disciplinary Barracks ordinarily disposes of its inmates by honorable restoration to duty, by dishonorable discharge to civil life at termination of sentence, or by transfer to a medium security disciplinary barracks. The turnover of inmates is surprisingly large for a maximum security institution, the average yearly turnover being well over the two thousand which is its normal capacity.

It is not definitely known when routine psychiatric ex-

aminations of all inmates of the United States Disciplinary Barracks were first instituted, but it is known that such examinations were made as far back as during the time of the First World War, and that they have been required by War Department regulations for many years.

Under current War Department regulations the psychiatric program of the United States Disciplinary Barracks as it affects the inmates is carried out in the Division of Psychiatry and Sociology, which has office space ample for its needs in the Station Hospital, a modern structure inside the walls of the institution proper. The principal duties of the medical officer, a psychiatrist, who is in charge of the division, are as follows: to maintain a permanent psychiatric and sociological register of each general prisoner and, when directed by the Commandant, of each garrison prisoner; to advise the Commandant in the selection of prisoners for assignment to the disciplinary company, restoration to duty, clemency, vocational training and guidance, schooling, and parole; to prepare extracts and summaries of psychiatric and sociological registers for boards requiring them; to maintain a library on penology and related subjects; to make such routine research and experimentation as may be feasible, and such special research and experimentation as may be ordered by higher authority; to be available for service on various boards; and to perform such other duties as may be desirable, provided they are not inconsistent with the nature of his work at the institution.

There are two psychiatrists in the Division of Psychiatry and Sociology. The psychiatrist who is in charge of the division is under the direct control of the Commandant: the other psychiatrist is primarily under the control of the Surgeon of the United States Disciplinary Barracks Station Hospital, and he serves as the neuropsychiatric ward officer in the hospital, but most of the time he functions in the Division of Psychiatry and Sociology under the psychiatrist in charge of that division. There is no psychologist assigned directly to the division, but all of the reports of the institution psychologist are readily available and are freely used in the preparation of the required

psychiatric and sociological registers. Three psychiatric social workers, all of whom are enlisted men, interview the inmates, and they prepare the original drafts of the neuropsychiatric histories which are later checked and revised by a psychiatrist at the time the complete psychiatric and sociological registers are compiled. The clerical staff consists of both enlisted and civilian personnel, but no inmate clerks are used due to the confidential nature of the work involved.

In the preparation of the neuropsychiatric case portion of a psychiatric and sociological register, every effort is made to render it as clear, as thorough, as practical, and as scientifically sound as possible. The use of involved medical terms is purposely avoided when other terms which will be more meaningful to those without medical training can be used. Four copies of each case history are made: one is forwarded to the War Department and three are distributed through the institution in such a way that they are readily accessible to those requiring them.

Some of the basic information used in compiling the psychiatric and sociological register is gathered by sending tactfully-worded questionnaires to parents, adult brothers or sisters, the wife if married, former employers, the family physician, the local police or sheriff's office, and former military organization commanders; some is obtained through the American Red Cross, which submits a social history in each case; some is received from the Federal Bureau of Investigation, to which agency a fingerprint card on each inmate is submitted routinely; some is taken from the reports of physical examinations, education level tests, and psychological tests done in other departments of the institution; and the remainder is obtained from the inmate himself in the course of personal interviews first with a psychiatric social worker and then with a psychiatrist, who does a through mental examination during the course of the same interview.

The neuropsychiatric case history which is then written includes all pertinent information arranged as follows: Military History, Family History, Personal History, Mental Examina-

tion, Physical Examination, Summary and Impression, and, finally, appropriate recommendations to a board of three line officers and one medical officer known as the Board of Psychiatry and Sociology. This board, of which the psychiatrist is a member, considers the recommendations to the Commandant in each case concerning assignment to the disciplinary company which is ordinarily a preliminary step leading to honorable restoration to duty, local parole, clemency, and the type of custody which is indicated. The Commandant then acts as he sees fit on the recommendations of the board, and he bases his own recommendations to higher authority on the approved or modified recommendations of the board. It should be mentioned that the board acts only in an advisory capacity to the Commandant.

The initial board hearing in each case is held as soon as possible after the arrival at the institution of the inmate concerned. After his first hearing, each inmate who has a sentence long enough to warrant it appears regularly once each year for his annual consideration for clemency. In addition, the board holds special hearings for consideration for assignment to the disciplinary company, honorable restoration to duty, local parole, change in custody classification, or clemency, whenever there are suitable indications for such hearings.

The Military History portion of the neuropsychiatric case history is a concise formulation of the inmate's military record, general court-martial orders, reports from former organization commanders, and other official military records. Each inmate is considered to be a soldier in confinement and one who may subsequently be returned to the service on an honorable status; therefore, the importance of this portion of the history is apparent.

The Family History covers the points usually brought out in such a history with emphasis on the past and present status of the relationship of the inmate's parents to each other; history of criminalism, alcoholism, and nervous or mental disorder in antecedents or siblings; and the family descent particularly if foreign-born.

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The Personal History, which is in general arranged in chronological order, covers the following points routinely as well as others which may be of interest in a particular case: birth data; early life, whether reared in urban or rural environment, status of relationship with parents and siblings, discipline in home; brief medical history with emphasis on subject's attitude regarding his health problems; school history; youthful ambitions, hobbies, special interests, leisure-time pursuits; religious life; employment history with emphasis on stability of work adjustment and with mention being made of institutional work assignment and his' attitude regarding it; habits as to use of alcohol or habit-forming drugs as well as to gambling and to the use made of financial resources; nomadic tendencies if any; criminal record including all conflicts with the civil authorities, institutional reports and aliases; sex life including information as to sexual development, promiscuity, indulgence in perversions, and status of relationship with wife if married; the inmate's version of his military history with emphasis on his past attitude regarding the service and his explanation of how he came to be involved in his military difficulty; and finally, his attitude regarding future military service, clemency, and local parole.

The Mental Examination, which is done by a psychiatrist, may be elaborate or simple, depending on the mental status of the inmate concerned. The matters usually concerned in a psychiatric interview are taken up and the results, including a statement as to whether or not the inmate is considered mentally responsible, are recorded. There is a growing tendency to avoid the routine use of formal psychiatric classifications and to use instead a dynamic psychiatric formulation of the psychiatrically significant points in each case. This includes the nature of his maladjustment, his potentialities with respect to salvageability, and the most effective methods of carrying out such rehabilitation as is possible in the individual case. The reports of the psychological tests which are actually done in another department are entered here also.

The Physical Examination brings out all of the signifi-

cant points as to the physical status of the inmate concerned, including a statement as to his physical fitness or unfitness for further military service. The physical examination is done by the staff of the hospital proper, but the report of it is filed in the psychiatric and sociological register. The physical defects noted at the time the physical examinations are done are subsequently corrected when possible, even if the inmate concerned is not considered potentially restorable, this being in accordance with a long-standing policy of the institution to send each discharged inmate out in the best possible condition physically as well as in all other respects.

The Summary and Impression is a summary of all of the significant points in the case history taken from any and all sources of information. At the conclusion of this section, the psychiatrist makes the recommendations to the Board of Psychiatry and Sociology which are subsequently acted on in the manner outlined above.

All interviews with inmates are conducted in a friendly but militarily correct manner, with a realistic approach to the problems involved in each case. The inmates are led to realize that the information obtained from them is to be used primarily for their benefit and that the confidential nature of disclosures made by them will be respected. It has been found that even the most hardened cases will respond well to tactful handling and to a display of sincere interest in the welfare of the individual concerned. Since the psychiatrist is an officer, and therefore a figure representing authority, he must initially overcome considerable latent or even open hostility on the part of some inmates, but this is readily done through tactfulness and sincerity of purpose. Some inmates ask that their relatives not be notified of their status as general prisoners, but such requests are denied since they are inconsistent with the honest and realistic approach to the solution of their problems constantly stressed during the interviews. In this connection it should be pointed out that as much psychotherapy as possible is given in each interview of a psychiatrist with an inmate.

The case of each inmate is systematically reviewed and a

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progress report is written by a psychiatrist twice each year as long as the inmate is in the institution. This report, which becomes a permanent part of his file, ordinarily covers the following points: any appreciable changes in his general attitude and mental status; a summary of additional information received from outside sources; his conduct, education, vocational training, and employment records in the institution; his family ties; his physical status including weight; and any administrative recommendations by the psychiatrist such as for a work change, a cell change, assignment to the disciplinary company, or some other appropriate measure. To facilitate the preparation of this progress report a progress check sheet covering some twenty significant points in the case history is routinely checked by the psychiatrist at the time of the interview for the progress report.

Inmates who require more frequent interviews than are routinely scheduled for psychotherapeutic or other reasons are seen by the psychiatrist if he is aware of the problem. Should some condition requiring psychiatric attention arise during the intervals between scheduled interviews, the inmates concerned can obtain such attention through referral from sick call which is held daily, or by submitting through the proper channels a written request for an interview with a psychiatrist.

An up-to-date library on penology and related subjects is maintained in the institution, but, because it is more readily accessible there, it is kept at headquarters rather than in the Division of Psychiatry and Sociology.

Lectures on psychiatric topics are given to both officers and enlisted men from time to time, and the psychiatrists constantly strive to demonstrate by example as well as to instruct their fellow-workers in the use of sound principles of mental hygiene in the handling of general prisoners. It has been found that the psychiatrist, whose role is primarily an advisory one, can be of value only as he gives practical and scientifically sound advice which is expressed in unmistakable terms and which is actually used by those for whom it is intended. He must successfully popularize his scientific knowledge and then

sell it in a practical, readily usable, form. The military mind is attuned to the use of streamlined "Yes, sir" and "No, sir" answers, and psychiatric opinions should be reduced to those terms when feasible. In civilian psychiatry the interests of the individual are usually paramount, but in military psychiatry one must often subordinate the interests of the individual to the interests of the group where the two come into conflict. The winning of a global war is the primary mission of the armed forces of this country; the personal interests of triumphant and medal-bedecked hero and those of disconsolate and discredited general prisoner alike must be brushed aside if they do not contribute in greater or lesser degree to the accomplishment of that vital mission.

Too much emphasis cannot be placed on the proper selection and training of guards, since they can and do exert a vast amount of influence on the inmates in their daily contacts with them. The psychiatrists are often called on to advise in the selection of enlisted personnel for duty at the United States Disciplinary Barracks, as well as in the matter of eliminating or correcting the deficiencies of those who are poorly adjusted in their work. A psychiatrist conducts an out-patient consultation in the form of a clinic for enlisted men who are having difficulties on a neuropsychiatric basis. If it is found that an individual case cannot be handled on an out-patient basis, the man concerned is admitted to the hospital for further observation and treatment.

The rehabilitation program is considered to be the total program of the institution, and no one agency can claim a predominant role in it. Every person who comes in contact with an inmate is capable of modifying his behavior pattern to some extent, and in a like manner every incident that occurs in the institution may have that effect as well. The psychiatrists are deeply concerned with the type of rehabilitation program which is outlined for each man, but they do not seek to dominate the program. They try to modify the individual's environment when indicated by advising in his proper handling by all who come in contact with him; in his proper assignment

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with respect to work, schooling, or vocational training; and in other related matters. Primarily, however, they are concerned with modifying the man himself, or rather with helping the man to modify himself in such a way that he gains insight regarding himself as well as a new orientation with respect to his proper role in the everchanging drama of life.

The psychiatrist's attitude is not one of praise or censure, but rather there is constantly in evidence a sincere desire to be helpful. An attempt is made to earn the respect and confidence of the men, rather than to create close bonds based on false sentimentality and maudlin sympathy. It has been found that even the most dishonest and devious persons can and do appreciate sincerity, a sense of fair play, and integrity in others. Military offenders are no exception, and they learn more by the example of those set over them than by anything that may be said to them by those in authority. A realistic appraisal of each inmate's assets as well as of his liabilities is made, and this is used as a basis for his psychotherapeutic program. An effort is made to have him develop and accentuate his assets and to eliminate or minify his liabilities, leaving at all times the basic responsibility for his development on himself. It is in the matters of honestly facing one's deficiencies and of accurately appraising one's assets that the therapeutic program often runs into the very real obstacle of the lack of true insight which is conspicuously absent in most of the inmates. They do not earnestly seek or honestly desire help because they recognize no serious deficiencies within themselves: rather they project the blame for their many difficulties by attributing them to bad luck, unhappy domestic relationships, mistreatment by others particularly by officers and noncommissioned officers, or to the taking of one drink too many. In this connection, excessive drinking is either directly or indirectly blamed for their personal difficulties by a very high percentage of the inmates, and it is difficult to make them realize that in most cases a more fundamental personality disorder is usually behind the excessive alcoholic indulgence which is, of course, only a symptom. It is a nice face-saving measure to blame it

all on excessive drinking and to ignore the more basic problems involved; therefore, many fail to gain adequate insight beyond this point.

It is not expected, by the writer at least, that spectacular miracles of rehabilitation will be wrought daily, but rather that gradual and at times almost imperceptible improvement should come about. Spectacular therapeutic changes have a perverse way of fading out as rapidly as they have appeared; therefore, such changes are not ordinarily sought. Parenthetically, it may be said that the ability to take the long view of things and to develop and maintain a sound philosophy of life are desirable attributes for those who work in a maximum security disciplinary barracks. Many of the inmates encountered are biological inadequates who have in addition been unfavorably conditioned throughout their formative years so one cannot expect so to transform such individuals that they can be sent forth at the time of discharge in the form of pure knights in shining armor. One must recognize one's own limitations as well as the limitations of present-day correctional methods, and not become frustrated because of the failures in rehabilitation which inevitably are encountered. On the other hand, one must expend the maximum of rehabilitative effort in all cases, since it is one's duty and since gratifying results are sometimes obtained in the most unpromising of cases. While it is generally recognized that most people are basically self-seeking persons who will respond most readily to any type of program which is heavily weighted in favor of self-interest, one must never fail to appeal to higher motives as well. Inmates of a maximum security disciplinary barracks are quite heavily weighted in the matter of self-seeking propensities so that in order to gain full cooperation in their own rehabilitation program one must appeal directly as well as indirectly to their selfish motives. This does not mean that the finer things of life such as patriotism, loyalty, and idealism can be neglected, but rather that a program based solely on such abstractions will have few participants among the earthy, self-seeking inmates of an institution such as the one under discussion. A well-rounded re-

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ligious program has been found to be indispensable at the United States Disciplinary Barracks, and patriotism is encouraged by constantly maintaining a high standard of military discipline as well as by having the population participate in military formations such as standing retreat.

Bibliotherapy has been found to be a valuable adjunct in the treatment of inmates at the Disciplinary Barracks. There is a large and well-stocked inmate library which is readily accessible to them, and it is used freely by most of the inmates. Many inmates have always enjoyed reading, whereas others take it up only after commitment as a means of whiling away the time. The psychiatrists advise in the selection of books on mental hygiene and related subjects for use in the inmate library. One which has been found particularly valuable is a book entitled *Managing Your Mind: or You Can Change Human Nature*, written by Kraines and Thetford and published by the MacMillan Company. It is clearly written in lay language and in commonsense terms. It is most useful with inmates who are of average or above average intelligence and who are sincerely seeking help in the solution of their personal problems.

Plans are being made for the organization of group psychotherapy classes at the United States Disciplinary Barracks so that inmates with similar or related problems can meet in relatively small groups to gain mutual benefit from group discussions led by a psychiatrist, as well as to derive whatever benefits may be possible from lectures given by a psychiatrist. It is believed that a background for the effective use of the group psychotherapy technique is now being developed through the present wide use of good literature, particularly the one volume named above.

Some of the special problems which may be encountered in a maximum security disciplinary barracks will now be discussed briefly.

The problem of handling overt sexual perverts has been a minimal one at the United States Disciplinary Barracks since the inauguration of the enlightened War Department policy of

considering such offenders who have not substantially transgressed the rights of others, as for example by the use of violence or by the seduction of minors, as being medical problems. The psychiatrist works closely with the prison court officer in the handling of the more serious violators of institutional regulations, that is, in the more serious disciplinary problems in the institution. Some of the frankly psychotic inmates who are believed to be chronically ill are disposed of by releasing them to the custody of relatives or of other agencies who can assure them of adequate care. Under current War Department regulations others of the chronically ill mental patients are sent for further care and treatment to mental institutions which are under the control of the Federal Security Agency, such as St. Elizabeths Hospital, Washington, D. C. Inmates with mental disorders which are of an episodic nature are, as a rule, successfully treated in the institution hospital, and they are returned to the population after their disorders have been ameliorated or cleared up sufficiently to permit them to adjust adequately there.

There has not been a successful suicidal attempt in the institution since it was taken over from the Department of Justice in 1940, but abortive suicidal attempts have been made from time to time. Each abortive suicidal attempt is investigated by a psychiatrist and appropriate corrective measures are instituted. Most of the suicidal attempts prove to be half-hearted or even faked efforts, made in a bid for sympathy or personal gain, but the possibility that each one may be a bona fide attempt is kept constantly in mind.

In instructing both officers and enlisted men in mental hygiene, the psychiatrist advises that they look for and report to the psychiatrist or other medical officer the presence of the following danger signals: moodiness, brooding, persistent insomnia, lack of interest in work or surroundings, poor appetite, surliness or quarrelsomeness in previously pleasant persons, marked seclusiveness, inability to understand and to carry out orders, talking to self, excessive masturbation or other sexual

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irregularities, wandering away from assigned place of duty, excessive preoccupation with health problems, startle reaction, signs of fear, excessive profanity especially in one not previously given to its use, forced gaiety, excessive weeping, unusual calmness in previously excitable persons, silly behavior and, in short, any marked deviations from usual patterns of behavior.

It has been found that emotional immaturity is one of the biggest problems in the inmates of the United States Disciplinary Barracks, so the use of all measures which will tend to force maturation is encouraged. The psychiatrist in his lectures on mental hygiene stresses the points that most of the inmates are persons of adult years but that they are children in their emotional reactions; that an effort should be made to develop a sense of responsibility and self-respect in each inmate; that the use of harsh or brutal methods in the handling of inmates not only reveals the weaknesses of those who use them but that it seriously retards the rehabilitation program of the institution as a whole; and that an impartial firmness combined with enlightened commonsense and a fine sense of fair play is the ideal approach to the solution of the complex problems which are constantly encountered in a maximum security disciplinary barracks.

At the time of this writing there is no follow-up system for inmates discharged to civilian life, but reports are received regularly regarding those who have been returned to honorable status in the army. An effort is made to secure civilian employment for all inmates who are soon to be discharged for return to civil life, provided the inmate concerned desires that service.

Since, despite all the rehabilitative efforts which may be expended in their behalf while they are at the United States Disciplinary Barracks, some of the inmates are still serious social menaces at the time of their discharge, it is believed by the writer that some nation-wide agency, possibly the Department of Justice, should concern itself with the more incor-

igible offenders to the extent of keeping them under observation, so that their socially dangerous potentialities could be kept within reasonable bounds after their return to civil communities all over the nation.

THE SOCIAL STRUCTURE OF A CRIMINAL UNIT OF A PSYCHIATRIC HOSPITAL

A. BROOKS BRANON, M.D.

The literature on the behavior of the criminal insane patient is rather scanty in comparison with that in other fields of psychiatry. There also is considerable misconception as to what actually takes place, on a day-to-day basis, in a hospital for patients in this category. It is with these thoughts in mind that a simple discussion or description of the behavior of a group of this sort seems to be in order. We will lay particular stress on the interpersonal relationships which spontaneously emerge. This subject, as far as we know, has not been presented from the point of view of criminal insane psychiatry.

First, a short summary of the source of our patients, the charges against them, and a description of the facilities available.

The male criminal psychotics of the state of Maryland are segregated at Spring Grove State Hospital in Baltimore. The average number of patients is sixty-five. These men come to the hospital from three sources: (1) any county court in the state, or Baltimore City Court, may send a man for treatment or observation; (2) any mental illness which develops in a prisoner in a state penal institution is treated here; (3) a few patients are transferred from the civil portion of the hospital because, for one reason or another, they have proved to be incorrigible. (These latter are, of course, not criminals strictly speaking, but their offenses are usually sufficient to have constituted a criminal act if committed outside a hospital.)

The seriousness of the offense is immaterial. If, after arrest, a man is found to be mentally ill, he is referred to us. Therefore, the charges vary from vagrancy to murder. The

psychiatric diagnoses are just as varied.* The hospital has prison status in that each day spent there counts on the patient's sentence, if any, and the duration of hospitalization is taken into consideration if a patient is tried and sentenced subsequent to discharge. This is helpful from a moral point of view.

As for facilities, we, along with a majority of hospitals, have felt the current pinch. Additions and corrections and a hoped-for new building have all, of necessity, been tabled due to wartime shortages of labor and materials. The present set-up consists of a separate building, considerably isolated from the rest of the hospital, which contains two floors, or wards. These wards house twenty-five and thirty-five patients respectively. Each ward has its own dining room, dormitory, and recreation room. There are also twelve isolation or seclusion rooms. The basement occupational therapy department has not been used for some time because of lack of attendants. Because of the legal angle, the patients are continuously under lock and key. Ground parole or special privileges are impossible. These facts are enumerated, not in a critical sense, but merely to show how little we have to offer the patient from a physical standpoint. However, with the present chronic shortage of trained personnel, it is doubtful if a more elaborate setup could be utilized even if it were available.

There is considerable patient turnover. With the census remaining around sixty-five, there are one or two admissions a week. Thus, patients of all ages, from 17 to 75, and in all stages of recovery and deterioration, are lumped together. This is of necessity and is unfortunate, but it does present a psychi-

*The following is a breakdown of the charges against the present group of patients. In some cases conviction has been obtained and sentence imposed; in many, commitment prior to trial was made.

Murder—16; Manslaughter—2; Assault with intent to kill—6; Burglary—3; Rape—8; Larceny—6; Robbery—4; Vagrancy—2; Arson—2.

One offender on each of the following charges: malicious destruction of property, incorrigible minor, nonsupport, sodomy, false fire alarm, disturbing the peace, resisting an officer.

Civil cases without criminal charge—10.

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atric melting-pot, the bubbling and occasional boiling of which is a rich experience to watch.

Particularly in the lay mind, the conception of crime and a psychosis in the same individual seems difficult. The expectation is that this must be a very hard group with which to deal. This belief undoubtedly stems, at least in part, from the fact that it includes a considerable number of men who all their lives have shown asocial and anti-social behavior, long before their psychotic days. However, it is equally true that it also includes many who have committed their first offense, and this, from the history, is directly attributable to the development of a mental illness.

Be that as it may, good or bad as far as their past history is concerned, the fact is that a very high percentage level off and make an adjustment toward life and association with the other patients.

Almost all of the patients have had a period in jail prior to admission. Unfortunately, this period is usually two or three weeks, occasionally longer. During this time, if the patient has been disturbed or particularly hostile about his circumstances, he usually has been in isolation and restrained by means of handcuffs or a strait-jacket. As a result, he is frequently unnecessarily upset upon arrival. Nevertheless, unless he is actually combative, he is told that he is starting with a clean slate and he is put directly on the ward. This may seem a waste of breath with a psychotic patient and occasionally it is, but usually the greater freedom in comparison with his former circumstances, and the calmness with which he is received by the other patients, have a sedative effect. The newness of the entire situation probably has somewhat the same result. Gradually he finds his comfortable place, as the bubble in a carpenter's level, and, unless he is too preoccupied by his illness, in the course of time is in a group around the radio, doing jig-saw puzzles, or in one of the several card games.

Of the 60 admissions in the past year only two are now in isolation. One is a thirty-year old paranoid schizophrenic who brutally beat his brother-in-law to death with a hammer. He

has been in the hospital about six months and his only thought concerning the crime is that he should have done it sooner. His inability to get along on the ward is due to his feeling that certain patients resemble his victim, and he has an uncontrollable compulsion to attack them. The other is a twenty-five year old mental defective, almost blind man with a massive elephantiasis of his lower right leg. He is going through a schizophrenic-like reaction, is very disturbed and tears off his clothing. However, he is improving and will probably be out of seclusion soon. He is serving ten years for burglary, and has been in the hospital for two months.

The above description of a patient's adjustment is greatly simplified. While this is primarily a spontaneous reaction it is influenced by many external factors. We do not pretend to know them all, but a few may be enumerated. With some, the fact that they are locked up under the watchful eyes of attendants and associating with obviously psychotic men has a sobering effect. This applies particularly to the psychopaths, alcoholics, and some mental defectives. (Patients in this group are sent to us because frequently their behavior is superficially difficult to distinguish from that of psychotic patients.) The relatively philosophical attitude of a majority of the patients and a realization on the part of the newcomer that they are "all in the same boat" is helpful. Frequently the other patients will put an unruly man in his place in self-defense. The concerted statement on the part of several that he'd "better pipe down or else" works at times when the efforts of attendants and physician have failed.

Some patients become tolerable ward patients only as a result of specific therapy. Examples of this are:

A forty-one year old paretic was admitted about five months ago with a minor larceny charge committed while drinking. He had a history of having worked for 15 years on one job, but six months prior to admission he gave this up and worked successively in three breweries. Upon admission, he was irritable, complaining, loud, argumentative, and very dogmatic. After a course of malaria and continuing chemo-

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therapy, he has gradually become cooperative, quiet, almost timid (much like his normal self according to his wife), and a good worker. He is now in charge of one of the patient dining rooms.

Another patient is a twenty-four year old Navy dischargee who was irritable, sullen, and very difficult. He was found to be subject to nightmares during which he would rise in bed, shouting at the top of his voice. Suspicion of epilepsy and a therapeutic test with luminal not only eliminated the episodes but thus far have made him a much more agreeable patient.

Psychotherapy is helpful in the adjustment of some. However, many, in fact most, have adapted themselves on a day-to-day basis some time before individual interviews are practical. Of course, a kindly, patient, understanding attitude mixed with firmness when indicated, from the time of admission, is a form of psychotherapy and is vitally important.

Some patients find religion an aid in becoming more comfortable with themselves and their environment. A case in point is that of a thirty-five year old mental defective whose weakness for arson makes institutional care a necessity. He was continuously full of physical complaints and a nuisance to all around him. About six months ago he began to listen to a national religious hour on the radio. He wrote for literature, and through this contact a local representative of the church came to visit him. Through his reading and periodic visits by pastor he has been much happier and has not mentioned his complaints for weeks. Previous efforts to modify him had been unavailing.

A certain group of patients, instead of needing a period of adjustment to hospitalization, find it to be the answer to their problem. Getting away from their disturbing environment produces an almost overnight change. We see this particularly in the so-called prison psychosis—a psychotic episode developing in a person usually without a previous psychotic history while incarcerated in a penal institution. Why these men clear up so rapidly in an environment very like a prison,

and with fellow patients who frequently are former fellow-prisoners, is an interesting point for conjecture. We have one man who, over a period of years, has been back and forth from the penitentiary seven times. No matter how disturbed he is upon admission, in 24 hours he is ready to resume his old job in a patient dining room. He is now eligible for parole but this cannot be granted while he is in the hospital and so far he has been unable to remain calm in prison long enough for a parole to be granted. This is an extreme case but there are others quite similar.

The value of experienced attendants in running a ward smoothly cannot be overestimated. The knowledge of when to loosen and when to tighten the disciplinary reins is not instinctive in many. In the main, it is the product of training and experience. We have been fortunate in having a small nucleus of experienced men in our building. In fact, there have been many days when this small group has been all we have had, and one man has had to handle an entire ward. (The normal complement is three men to a ward.) Yet, it can truthfully be said that under an able attendant the patients get along much better than under two or three new and inexperienced men. The difference can be felt just by walking into the ward. The air is tense, men are pacing the floor, some are sitting sullenly in a corner, and several come up to register complaints of real or imagined injustice. The new patients are not satisfied by the inexperienced attendant, and the old patients try to take advantage of him.

If factors influencing patient adjustment and interpersonal relationships were being discussed in order of importance, time would probably head the list. Many patients adjust tolerably quite rapidly, but there is a small group which adjusts with great difficulty. Here "time" is the only "answer." The schizophrenic or organic patient may be able to float on the ward only after deterioration has brought him to an almost vegetative level. The paranoid schizophrenic and frequently the manic may mellow with the passage of time. The unstable,

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immature individual may "grow up" sufficiently to be able to get along.

An ordinary ward-walk reveals a rather tranquil prospect. There are usually several card games in progress. Double pinochle is the favorite of some and it is a rather strange sight to see two schizophrenics, a psychopath, and a mental defective enjoying a heated game. Rummy, casino, and solitaire are also in evidence. Jigsaw puzzles are popular and a few are in almost constant use. Men are gathered around the radio. Some are reading comic books and popular magazines; mysteries find the most favor. Some are paired off in conversation and a half dozen or so in each ward are sitting, staring into space, oblivious of their surroundings.

In general, these little groups function as units independently of the others. There is very little overlapping. Once a man has found his level, his friend or small group of friends, he is quite inclined to stick with it. This is true to a marked extent. A fight, a heated argument, or an acutely disturbed patient will usually be ignored or at most smiled upon tolerantly by those not directly involved. The exception to the isolationism, as it were, is seen when a patient shows improvement. He then graduates to a more active, more alert group.

Usually the picking of companions and the formation of groups is done on an intellectual basis. That is, the mental defectives and the deteriorated patients pair off, and so on up the line; but this is not a constant finding. Some of the mental defectives who are relatively stable are leaders in the few group-activities possible; and, conversely, some of the more intelligent, because of their preoccupation and reduced psychomotor activity, are found below their expected level. Then there are some associations which superficially have no rhyme or reason. An example of this is the almost interminable card game enjoyed by a "burned-out" paretic and a fairly well-organized paranoid schizophrenic.

It is felt that the Rorschach Analysis may show a common denominator in the basic personalities of these seemingly mismatched people.

Quite a few of the men become specialists of a sort. This varies from really helpful work to merely ways of passing the time. One patient has a ward of twenty beds which he makes to a perfection which would be the envy of any nurse. This man is a defective deaf mute. Another, an old paranoid, rolls really fine cigarettes for almost the entire ward. A couple of schizophrenics act as group stenographers in writing letters for those unable to write. Several of the patients weave very acceptable baskets of willow. One man claims he can put jigsaws together faster than anyone else in the building. Another spends his time fashioning intricate designs and models with paper and string. Still another makes himself very useful by his ability to do repair work on a sewing machine. At least half of the men are doing some work, in the dining-room, making beds, polishing the floors or hardware, dusting or sweeping.

Just as the seriousness of the crime has no bearing on whether a man is sent to the hospital, so it has no bearing on his treatment in the hospital. The average attendant, coming and going as he does these days, has no idea of the crime committed by the individual patient. The patients are accepted as mentally ill men, not as criminals. It is our feeling that the mentally ill person who happens to commit a serious crime, even murder, in the course of his illness should not be punished after he reaches a mental hospital more severely than another person who had the same ideas but did not actually do the deed. The sole criterion as to whether a man is allowed on the ward is his proven ability to adjust to ward life. If he fails at first, he is given repeated chances, until he does adjust if it is possible for him to do so.

It should be mentioned that the psychoses encountered are the same as in any mental hospital with the exception of true depressions. The relative absence of these is probably explainable on the basis of the lowered psychobiological activity of the depressed not being conducive to the mental and physical exertion necessary for most crimes. About the only depressive reactions seen are in the transfers from penal institu-

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tions where the outlook of years of incarceration is frequently overwhelming.

From what has been stated thus far, it might seem that all is smooth sailing. This, of course, is not the case. Fights occur; plans for escape are formed and occasional attempts to escape are made. But these are not frequent and are obviously not peculiar to the criminal insane.

It is to be expected that acute psychotic episodes will occur. Experience soon shows which patients are most subject to these flare-ups, and sufficient warning is usually given by the patient to allow for seclusion prior to physical violence. If warning of a blowup is not present, or is missed, the violence when it comes is short-lived, and since anything which might be used as a weapon is kept off the wards, serious damage is rare. Some of the patients invariably come to the aid of the attendants in quelling these disturbances, regardless of whether the attack is on an attendant or a patient. In some, these periods of disturbance are cyclic, occurring at fairly regular intervals and without apparent relationship to their environment: but in others, they are directly traceable to agitation by one or two individuals. In this the constitutional psychopath is the chief offender, although an untalented defective or a hypomanic individual can be equally troublesome.

Many mental hospitals have no dealings with the full-fledged constitutional psychopath. In this they are indeed fortunate. Some have said that the psychopath, since he is not psychotic, usually is a good patient in an attempt to be discharged as soon as possible and continue his "career". This generalization is certainly not true in our experience. The psychopath is our greatest single cause of a disruption of the interpersonal relationship of the patients. Here are a few examples of the type of behavior encountered in such a man: he will take great delight in teasing and taunting a psychotic patient until he blows up; he will be the leader in planning escapes from the hospital, usually with one of his accomplices scheduled to do the dirty work; he will be openly defiant about obeying orders, thus lowering the morale of the entire ward;

he will turn "informer" and tell lies about the behavior and the plans of other patients; and he is full of talk of the legal aspects of the situation, the Bill of Rights, habeas corpus proceedings, etc., which start a clamor for "our rights" among the other patients. It is our belief with the group under discussion that if psychopaths were not admitted many of the psychotic patients would be discharged much sooner.

Mental defectives have been mentioned frequently above, and the question may arise as to why they are in a hospital with psychotic patients. Since they are sent to the hospital on court order, they have to leave by the same route. But here the legal definition of insanity enters the picture. Is this man able to tell right from wrong and act upon this knowledge? Is he able to comprehend the seriousness of his crime and to defend himself in court? If the answers are in the negative, he stays with us because invariably he is too old for the State institution for defectives and there is no other place for him to go. This is a very unfortunate situation because the unstable defective is frequently a disturbing influence and, in all fairness, it is not the proper place for him.

Considerable space has been devoted to the mental defective and the constitutional psychopath for two reasons. First, to point out their detrimental effect on the interpersonal relationships of this group and the feeling that they definitely do not belong in a hospital with psychotic patients. (We are referring to the defective and psychopath without psychosis. If they have a superimposed psychosis, that is a different matter.) Secondly, although we are philosophical about the present situation, we feel that there is no hope of future beneficial change unless these facts are repeatedly brought before the proper authorities until recognition of them is obtained and action taken.

By way of summary the following points seem pertinent:

(1) In spite of the wide divergence in ages and diagnosis, the average patient finds his level and makes a reasonably good adjustment with his fellow patients. Social groups which help to stabilize the situation form here as elsewhere.

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(2) It is reasonable to assume that the interpersonal relationships would be improved if mental defectives and psychopaths were excluded. They do not logically belong in a hospital with psychotic patients.

(3) The psychoses found here are no different, essentially, than in any other mental hospital.

(4) It is probable that, in spite of their poor history from a social point of view, this group is no different, on a day-to-day basis, than any other group of sixty-five mentally ill male patients.

PSYCHOPATHIC BEHAVIOR DISORDERS IN CHILDREN

LAURETTA BENDER, M.D.

In ten years (1935-44) over 5000 preadolescent children (under 13 years of age) have been under observation on the Children's Ward of the Psychiatric Division of Bellevue Hospital. The majority (65% to 75%) of these children have presented problems in behavior with neurotic mechanisms. The causative factors have been conflicts and aggressive reaction to frustrations common to all of us in our culture but exaggerated in these children. Unsatisfactory experiences in their personal relationships are due to (1) inadequate and distorted parent-child relationships in the early childhood period (before five or six years of age), because of at least one absent or seriously asocial, psychotic, defective, or otherwise unsuitable parent; (2) social - economical - emotional deprivation in social minority groups; (3) serious language handicap, such as a language disability, including reading disability and intellectual limitations or a relatively alingual home (*i. e.* Porto Rican families). Usually only one of these factors is not enough to cause a serious behavior disorder in a child, so wide is the margin of safety in the development urge for normalcy. Another 10% to 20% of the children are handicapped by some organic brain disorder, such as developmental defects or one of the degenerative, inflammatory or traumatic encephalopathies. The brain disorder alone may account for the behavior disorder if it is associated with a considerable disturbance in brain tissue or a progressive process, or if it is associated with epilepsy. However, in many of the traumatic encephalopathies and non-progressive inflammatory encephalopathies and developmental deviations, a behavior disorder, if it is present, will be found to be related to the conflicts, frustrations and deprivations subsequent to the pathological process and any related or in-

cidental disturbance in family, social and language background. Children with progressive encephalitis or encephalopathy (especially with epilepsy) may present a psychopathic type of personality. In contrast to the psychopathic behavior disorders, however, they usually manifest some neurotic reactions such as anxiety, feelings of guilt, and inadequacy in response to the frustration imposed upon them by the organic pathology, especially if the frustration involves their interpersonal relationships. Such neurotic features are an aid in diagnosis, make the prognosis more favorable, and offer the therapist an approach to the child that is often very gratifying in its results. Schizophrenia in childhood appears to be closely related to the progressive encephalopathies. A neurotic response, with anxiety, to the frustrations which the schizophrenic personality must face, is evident in the early stages and often confuses the diagnosis. However, this neurotic reaction is at present our only means of a therapeutic approach to the personality while the patterned functions are being disorganized by the schizophrenic process.

There still remains a group of children representing 5% to 10% of the whole which we will refer to as psychopathic behavior disorders in children. This group of children presents a clinical picture which forms a syndrome in that the causative factors in the early life of the individual are known, the developmental course may be anticipated, the behavior pattern is typical and closely resembles the classical description of the so-called constitutional psychopathic personality. Moreover, psychological tests for personality show a specific patterning and the response to various treatment programs is known.

The study of these children has resulted in important contributions to modern psychopathology. It not only has thrown light on the question of the psychopathic personality, but has made possible a preventive program and also has brought new data to some controversial problems about the normal personality structure and the development of various personality functions and dysfunctions.

The cause of the condition is emotional deprivation in the

infantile period due to a lack or a serious break in parent-child relationship, for example, the child who has spent a considerable time in infancy or early childhood in an institution without any affectional ties, or a child who has been transferred from one foster home to another with critical breaks in the continuity of affectional patterns. The defect is in the ability to form relationships, to identify themselves with others and, consequently, in conceptualization of intellectual, emotional and social problems and asocial or unsocial behavior. The developmental processes in the personality become fixated at the earliest stage; there are no satisfactions derived from human experiences and no anxieties because there are no conflicts. The ego is defective and there is no superego. After a certain period this fixation in the development of the personality can no longer be overcome or corrected because a therapeutic or transference relationship can not be obtained. This is the reason for the difficulties in treatment. Prevention is possible by avoiding such deprivation in the early infantile period and insuring against critical breaks in the continuity of close personal relationships in a family circle, from the early weeks of life until the child is well out of the infantile period and in the middle childhood period. Once a child can exhibit independent behavior, enter into new relationships with adults and children—as the child does when he goes to school at the age of 5 or 6 years—he can show that his personality has safely developed beyond the period when such breaks or deprivation will any longer be critical. Freud originally placed the superego development at $3\frac{1}{2}$ to 5 years. Melaine Klein shows that there is evidence of super-ego formation well inside of the first year. In general, it seems that the younger the child at the time of the deprivation, the more serious the effect upon the personality. The first year is, therefore, the most vulnerable, although prolonged or critical breaks in the continuity in parent-child relationship during the second, third and fourth years often distorts the personality in the direction of a social agnosia rather than in a neurotic reaction type. A critical break is one in which the child completely forgets the parent, or in which

the relationship is completely broken and the new one does not establish itself on a similar pattern.

Margaret Ribble has shown the need of mothering to the new-born and young infant for its immediate well being and its future personality development. It has been known for a century that the hospitalized or institutionalized child might suffer even death, or marasmic physical states, and pronounced deficiencies, or deterioration in mental and personality development. Hans Christoffel (Switzerland) has quoted Parrot, a great infants' clinician of the nineteenth century (1839-83) in France, to this effect. Emperor Frederick the Second was said to have experimented in the fifteenth century with an attempt at raising infants without demonstrations of affection; and they all died because they were "without the appreciation, the facial expression, friendly gestures and loveable care of their nurses" (quoted from Salin Benes, the monk). Hildegard Dufree and Kathe Wolf found that infants raised in proletarian infants' and children's homes in Vienna could be in good physical condition where the emphasis was on physical hygiene, but suffered in mental and emotional development.

A large number of problem children at all ages have been brought to Bellevue for observation from the different child-caring institutions and foster home agencies. They have represented almost a laboratory experiment in personality structure. In many children there has been a profound inhibition in personality development, while in others various degrees of a similar personality defect. In children who have been in institutions for the first two or three years of their lives without a parent who visits frequently and takes an interest in them, we find the most severe type of deprived, asocial, psychopathic personality deviation. There is a lack of human identification or object relationship and an inability to experience such when therapeutic efforts are made to offer such a relationship to the child. There is a lack of ego or super-ego awareness. There is a lack of anxiety or any neurotic structure as a reaction pattern to conflicts or to frustration. There are no conflicts, and frustration is reacted to immediately by temper tantrums: There

is an inability to love or feel guilty. There is no conscience. The unconscious fantasy material is shallow and shows only a tendency to react to immediate impulses or experiences, although there often are abortive efforts to experience an awareness of the ego or to identify the personality. Their inability to enter into any relationship makes therapy or even education impossible. There is an inability to conceptualize, particularly significant in regard to time. They have no concept of time, so that they never keep pace with any schedule, have no attention span, cannot recall past experience and cannot benefit from past experience or be motivated to future goals. This lack of time concept is a striking feature in the defective organization of the personality structure or patterned behavior. The biological instinctual needs and tendency to normal development drives the child to activity which never satisfies him and is the chief source of frustration. There is a drive to use perceptual patterns as a mode of experience, and it is thus that they tend to imitate the behavior or ideology or art expressions of other children. This gives us our best lead as to the care and training of such children. They should be placed in a benign institutional set-up, organized with well routinized and patterned social and educational activities, in small groups of children where they can fall into a routine and imitate other children. They should not be expected to take any responsibility for their behavior, to make any decisions, to profit by their or others children's mistakes, or to be motivated to future goals. Corrective discipline or insight therapy have no place in their training.

Helen Yarnell and myself, in a survey of 250 children under the age of six years who had been on the Children's Ward during the five year period from 1934-39, found that about 10% or 12% of this group were referred from child placing agencies because of this type of problem. One agency was without psychiatrically trained workers at that time. The boys were placed in foster homes and there was no effort to make them feel emotionally secure. In fact, it was felt that an attachment between the child and the foster parent should

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be discouraged, and frequent changes in foster home placement was a part of the program. These boys were usually referred to us between five and seven years of age when they failed to become part of a school or community group because of their extreme infantile behavior, the wild disorganized activity, their inability to relate themselves to anybody or any group, or to become satisfactory members of a foster home or school room.

Another group consisted of children who were placed in infancy in an infants' home of one agency. The children were given the best physical and pediatric care and were well developed and healthy, but they were deprived of all affectional ties, social contacts and even play materials. As a result, they all appeared retarded in speech, in patterned behavior, even in motor functions, and in social and personality development. At a little over three years they were transferred to foster homes in which they usually could not adjust and were then moved to several other trial homes; each time they became more difficult. They appeared to be unable to accept love or the pattern of life in a home situation because of the deprivation of institutional life for the first three years. There were instances in which the deprivation was limited to within the first year, but these children showed the same personality retardation and distortion. It appears that some children of this type may be acceptable to a very tolerant foster mother if she either can give all her attention to the child or if she is insensitive to his unpatterned, impulsive, infantile, unresponsive behavior, and if there is no other child of a similar age with whom he must compete in the home. Even such children do not mature and their behavior never becomes patterned or acceptable when they reach school age.

These children do not develop a play pattern; they cannot enter into group play with other children, but abuse any child near them as frustrating objects to the satisfaction of their own impulses. They seek adults for constant contact but are never gratified by the contact and have temper tantrums when any impulse arising from instinctive needs is frustrated, or

when any type of cooperation implying either interpersonal relationship or patterned behavior is expected. They are hyperkinetic, distractible, short in attention span, subject to uncontrolled mood swings, lacking any concepts of human relationships. They speak of having many mothers and fathers and say that everybody is their brother and sister. They love themselves or "God" or the nearest person to them, or "all the mothers and fathers and brothers and sisters". These children do not respond to the group nursery care on the ward as children do who have had some sort of parent-child relationship. Our follow-up study on ten of these children in 1939 showed that some of them had settled down during the latency period in orphan homes and some had been accepted by particularly tolerant and undemanding foster mothers. All remained infantile, unhappy or affectless, and unable to adjust to children in the schoolroom or other group situation. At that time we classified these children as psychopathic personalities which had been caused by emotional or social deprivation during the formative infantile period. A failure to identify themselves in an interpersonal relationship was the essential psychopathological mechanism.

We also observed a characteristic curve of the Stanford-Binet intelligence quotient during the childhood period, indicating a specific intellectual retardation which results from the non-stimulating experiences of their infancy and the inability to utilize identification processes for psychic development. For example, Harry was placed at birth in the infants' home. His physical development was normal. At three years he was examined in the home before placement and scored an IQ of 78. At four years, after failing to be accepted in two foster homes, his IQ was 83. At five he was back on our ward following six foster home experiences, and his IQ was 85. At eight years (in our 1939 follow-up study) his IQ was 88, he was failing to do any work in school. At eleven years his IQ was 75, and institutional care was the only possible recommendation. Albert's IQ was 68 at four years when he was leaving the infants' home, it was 75 at five years, 86 at six and a half, 95

at nine as he was placed in an institution, and 82 at 11. The child shows clear evidence of retardation as a result of 3 or 4 years of socially depriving institutional care, and then shows accelerated development of intelligence under the more stimulating influence of the foster home, community and school life to the eighth or ninth year, and then a retardation again because of his inability to apply himself to school work and to acquire learned techniques or social or verbal insight.

Maizie Becker in 1941 made a follow-up study of twenty-five boys who had been on our ward and presented psychopathic behavior problems. Half of these boys came from the same infant home experience described above, the rest from other agency type of care for the dependent child. Their ages were nine to fifteen at the time of the follow-up, and five to thirteen at the time they were first seen on the ward. Her conclusions were that the study confirmed Dr. Yarnell's and my observations on the nursery age children that "children who have been brought up in institutions where personal stimuli are lacking (or have experienced repeated breaks in affectional ties through frequent shifts in foster home placements), and are emotionally under-privileged, have no feelings for human relationships, are asocial in their behavior, and have no capacity for anxiety or guilt." She found that "an institution regime seemed to afford the best facilities for the care of this type of child. In the majority of cases no change in the emotional structure had occurred. In a few instances boys had been able to form attachments to foster parents. In all these cases it was possible to confirm that the child had had a relationship throughout his institutional experience with a mother. There was one exception that could not be accounted for."

In 1940 Lawson G. Lowery made a report on the children from this same agency under the title of "Personality Distortion and Early Institutional Care". He reported twenty-eight children from the same infants' home who were subsequently referred to him for psychiatric advice because of serious problems in social adjustment. He stated that "the conclusion seems inescapable that infants reared in institutions undergo an

isolation type of experience with a resulting isolation type of personality characterized by unsocial behavior, hostile aggression, lack of pattern for giving and receiving affection, inability to understand and accept limitations, marked insecurity in adapting to environment. These children present delays in development and intensification as well as prolongation of behavior manifestations at these levels. At the time of transfer (from institution to foster home at 3½ years of age) they are at a stage where they can form only partial love attachments." Lowery concluded that, if the transfer was to occur at this time, it should be cushioned by the experience of being in a small group intimately in contact with warm adults genuinely interested in them, but that preferably they should not be transferred from an institution to a boarding home when negativism is at its peak. More significant seems his conclusion that "infants should not be reared in institutions, or at least for the shortest possible time; otherwise the institutions should furnish such intimate personal planned contact with at least one adult."

It is of interest that Anna Freud, in her experiences with young children in nurseries in England during the war, also came to the conclusion that serious personality disorders in children might be prevented by creating a family-like situation in the institution with one adult relating herself closely with an expressed mother relationship to only two or three children. It is apparently true that some children are raised in institutions through the early infantile period and show a normal personality development. Usually it is possible to show that such children have been regularly visited by a parent (in one instance, at least, this was the father), or that someone in the institution took a warm and continuous interest in the child, acting as a satisfactory parent substitute. David Levy in 1937 used the term "affect hunger" in describing a group of problem children brought to his attention by the Child Guidance Clinic, a number of whom had suffered similar deprivations in their earlier lives, although some had been "rejected" children and others "spoiled" children of over solicitous mothers.

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William Goldfarb has made most important contributions to the study of the personality deviations in children by studying children who in their infancy had been in the same infants' home we have referred to above. His first study was in 1943 on "Infant Rearing and Problem Behavior". He based it on the "suggestive data that in 1938 children were referred by the foster home agency to Bellevue Hospital for observation because of extremely poor personal and social adjustment. Investigation of their background disclosed the startling fact that all had spent their infant years in an infant institution. The problem was described in six cases as a behavior disorder with symptoms of aggression, hyperactivity, quarrelsomeness, disobedience, destructiveness, restlessness, stubbornness and shallowness of affect. In one the problem was stubbornness and ease of emotional upset." Goldfarb made a series of carefully planned and controlled studies of children who had spent their first three years in this institution and then were placed in foster homes under supervision of trained psychiatric social workers, comparing them with matched children who had been placed in foster homes from their earliest infancy. His studies included behavior, personality and intellectual development, using the case records and questionnaires of the social workers, interviews, observation, and clinical psychological tests on the children. He found important and sharp contrasts between the children who had spent their earliest years in infants' homes and those who had been from the beginning in foster homes. The first group were more retarded in general. Behavior was characterized by destructiveness, consistent failure regarding privacy rights, antagonism and cruelty to other children as infantile modes of expression. There was speech retardation, relative mental retardation, poor school adjustment. It was noted that those children who had been cared for entirely in foster homes also had problems, but they were more heterogeneous and, specifically, there was more "passive anxiety" as compared to aggression in the institutional children. This may be interpreted to mean that there were more neurotic features or mechanisms in children who had always been in

a home or family situation, and that the unpatterned impulsive overactivity of the institutional children showed no neurotic or anxiety mechanisms.

In Goldfarb's comprehensive paper, "The Effects of Early Institutional Care on Adolescent Personality", he compared two groups of adolescent children then in foster homes, but the first group had been in an infants' home for the first three or more years. He says, "It would appear as though the early group experience of the institution children was a highly isolating one. The emotional and intellectual deprivation resulting from the absence of adults produced a series of distinctive personality traits. These children continue to be different from a group of children with continuous family experience even as late as adolescence and even after a long period of foster family and community contact. They remain less well adjusted to the demands of the community group, more simple in their mental organization, less capable of making reflective and complex practical adjustments at school and more important, less capable of normal human relationships." He attempted a general theoretical formulation, but his most important conclusions dealt with the "specific implications for the field of child care since all of the institutional children were reared in early infancy in what the field of child care has regarded as one of the better infant institutions and it is unlikely that other institutions have been supplying a more personalized type of care". Significantly, the mean IQ (Bellevue-Wechsler) for the "institution" group was 72, and for the foster home group was 95, the difference being greater for verbal function than performance function. Conceptual thinking was especially defective and proportionally more so than in mentally defective children of a similar functioning level. Rorschach tests on this same group of children demonstrated that the "institution" children showed more deviations from the norms in that they were more concrete and inadequate in conceptualization, which indicated an apathy in relationship to the environment, behavior that is unaccountable and without conscious purpose.

From these children we have learned that the emotional

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deprivation which results from spending the first three years in an institution may produce an irreparable distortion of the personality with the features of infantilism, lack of patterned behavior with an aimless hyperkinesis, apathy, relative retardation in intellectual development most severe in the fields of conceptualization, language development, and inability to make an object relationship or to give and take in any human relationship.

It is needless to say that on the Children's Ward at Bellevue Psychiatric Hospital there have been many other children with psychopathic behavior disorders besides those coming from this particular infants' home. Some, indeed, may have spent no time in an institution, but may have been changed frequently in foster homes, so that the child was unable to maintain any continuous relationship or identification with any one parent or parent substitute. It appears that there may be two different causative factors. One is the absence or inadequacy of emotional, social or cultural stimuli which is a part of the institutional life of children and which is related to the intellectual retardation, apathy and lack of patterned behavior. The other factor is the absence of, or critical or repetitious breaks in, an identifying close adult-child relationship. This alone may produce a severe and irreparable distortion in personality of the psychopathic type. In these children the intellectual retardation may not be so marked, but the children will never function intellectually at their maximum because of inability to identify themselves with a teacher or a school room situation or with social concepts, due to lack of motivation, poor attention span, poor work habits and techniques, and defects in patterned behavior and conceptualization. Unsuccessful satisfaction-seeking behavior and a complete infantilism in personality is most characteristic of these children. They are overactive and socially and physically destructive without being hostile in their aggression. They show no neurotic features and are therefore without anxiety, guilt, or any positive or negative human emotions of love or hate. From several children such as these, we have learned that the critical age is certainly un-

der two years (the period of language development is undoubtedly critical) in some cases it is definitely under one year. A serious deformity in personality might occur in a child in which there had been a critical change in parent relationship before the latter part of the first half year of life, because that is the period when children first identify their parents and show a definite and individual relationship to the people around them. However, it also appears that a very critical break in total family identification during the second, third, and fourth years may produce the same personality distortion. If there is no chance to carry on any of the earlier identification processes, all memory of them is lost or distorted and the normal processes of personality development cannot continue. It is probably true that in these instances severely traumatic experiences such as abusive or neglectful care, long periods in impersonal shelter care, or severe illnesses with hospital care, may be contributing factors. But these only serve to make the really critical factor, namely the break in identification processes, a telling one. Patterned behavior, conceptualization, depth and reality in object relationship in normal human development, are therefore dependent upon the continuation of such experiences through the early critical years of personality development.

Psychopathic behavior disorders are quite common among adopted children when the child has been adopted in this early childhood period especially from institutions, or after a period of neglectful care or too long a period in a hospital. This type of behavior disorder is also seen in children of the upper economic and social levels when the child has been left in the care of rapidly changing servants, and when the relationship to the mother and father due, in part perhaps, to their many business and social obligations, has been too scant to permit of any real opportunity for identification, normal interpersonal relationships, and personality development. The first case in Helene Deutsch's paper on the "As if Personality" is an example.

SUMMARY

1. These children impress us with their diffusely unpatterned impulsive behavior. At all levels it is unorganized and it remains unorganized. It is exceedingly difficult to find any educational or psychotherapeutic method whereby it can be modified into organized or patterned behavior. The child is clearly driven by inner impulses which demand immediate satisfaction; these impulses or needs show the usual changes with physical and chronological growth of the child, but even they do not add much pattern to the behavior. Motivation, discipline, punishment and insight therapy have little effect. Controlling the environment in which the child may act, to which he may respond by imitation, seems the only means of producing social patterns, and even this is superficial.

2. The behavior remains always infantile. It is true that there are some differences in different individuals as to the level of the infantile fixation. It is certainly pre-oedipal, pre-super-ego, and usually pre-narcissistic. It is as though a new born infant had urgent needs which must be satisfied. Screaming, kicking or temper tantrums or disturbed behavior of which the larger child is capable continues when frustration occurs, as it must a good deal of the time. All kinds of oral activity, clinging, wetting, soiling, senseless motor activity, genital manipulation may be observed. These are not neurotic traits and do not indicate regression but retardation in personality development. In some instances they may be given up through a quiescent period only to recur again when inner drives are great or outer satisfactions less. Psychopathic behavior disordered children are often attention-seeking, clinging, passively dependent, seductive and, with it all, amiable. This may be mistaken for an attachment or interpersonal relationship. Actually, there is no warmth, and the relationship can stand no separation or disappointments or demands: it shifts for the nearest new object as soon as the recipient is out of sight. It seems probable, however, that they finally find such a relation-

ship upon which they can depend, especially after the strongest of the youthful impulses have subsided, as the psychopathic individual seems to disappear in early adulthood.

3. The primary defect is an inability to identify themselves in a relationship with other people, due to the fact that they experienced no continuous identification during the early infantile period from the first weeks through the period when language and social concepts, and psychosexual and personality development, were proceeding. Related to this lack of capacity to identify or to form an object-relationship is a lack of anxiety and inability to feel guilt. It would thus appear that anxiety and guilt are not primary or instinctual qualities, but that they arise in reaction to threats to object relationships and identifications. This is of great theoretical significance in the whole area of the psychology and psychopathology of personality.

4. There is a serious defect in language development. In the youngest child this is the whole field of language. Later it concerns itself more with the semantic function of language and especially with conceptualization and social concepts. Cleckley emphasized this semantic defect, while Reich referred to a "social agnosia". Goldfarb has studied the conceptual difficulties and general interference in intellectual development. The earliest identification with the mother and her constant affectional care during the period of habit training, formation of concepts of the family unit, and language development, are necessary for the later higher semantic and social development.

5. There are tendencies to rhythmical fluctuations in behavior which may be looked upon as mood swings and may sometimes be confused with manic-depressive states. This is particularly true of the adolescent period. The mood swings are related to internal biological drives which always tend to show some rhythmical behavior. It is as though the biological unit under the pressure of inner drives or needs could move along at a certain rate only so long before swinging into a new pace.

6. There is an imitative, passive "as if" quality to the be-

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havior of the older children and adolescents. This is because there is an inner drive to behave like a human being. Whereas behavior in the normal child arises from internal mechanisms, such as identification processes, object relationships, anxieties and symbolic fantasy life, the psychopathic child has no such inner life but still has the physiological or intellectual capacity to perceive and use symbols and patterned behavior. It, therefore, copies the behavior of other children, according to its maturation level and ability. This is done in an effort to understand what other children are experiencing. Confabulations have the same meaning. Ridiculing and caricaturing behavior of others is on the same basis.

7. Once the early childhood has been passed without the adequate opportunity for normal relationships and personality development, the organization of the personality permits no modification. These children do not show a change in behavior by sudden confinement to a restricting institution as all other children do. Their behavior is not modified (in part because of the semantic defect) by insight therapy or transference therapy because they cannot relate themselves to anyone. Our experience has led us to the opinion that in early childhood there should be patient efforts to establish habit training, socially acceptable behavior and language by one attentive mother figure in the home situation. Once the defect is present, however, this will only accomplish a superficial effect, the underlying defect in personality will persist and assert itself. From about the eighth or ninth year into middle adolescence, the best program is a small closed institution with other children of a similar age. Here the psychopathic child can be expected to fall into the carefully controlled routine and to imitate the behavior of the other children about him. He need have no responsibility for making decisions about his behavior. Nothing is expected in regard to goals or ideologies. Later, if he can become attached in a dependent role to some institution, or person, it may be that he will not be socially destructive.

8. The defect in time concept is one of the most signifi-

cant problems. This may be related to the lack of identification as a continuous temporal process. Even in those children where the problem was a lack of a continuous personal relationship, the same may be said. It appears that we develop our time concept from the passage of time in our earliest love relationships. These children do not remember the past, they cannot benefit from past mistakes; consequently, they have no future goals and cannot be motivated to control their behavior for future gains. There is a somewhat similar defect in spatial concepts. Thus, even when they become momentarily attached to a person, they loosen the attachment when the person is absent. This defect in time concept may be tested by suitable clinical tests. It is related to the problem of lack of pattern in all behavior.

9. Finally, we come again to the origin of this specific defect in personality development in children. It is not a hereditary or constitutional defect. It is caused by early emotional and social deprivation, due either to early institutional or other neglectful care, or to critical breaks in the continuity of their relationships to mother and mother substitutes. We know that the critical time is the first three years, especially the first year; any sufficient break in parent relationship or period of deprivation under five years may be sufficient to produce this personality defect. Once the defect is created, it cannot be corrected. However, we know a good deal about what we should do to prevent such psychopathic behavior disorders. No child during the first years of its life should be placed or left in an institution for any period of time, even a few weeks in the first year of life is probably too long. If an institution is to be used, it should furnish for each individual child an individual adult who will enter into a continuous, warm, human relationship with him and replace his parents in this relationship. When hospitalization is necessary for infants, it should be as brief as possible, and should provide regular parental visits. Babies put out for adoption should be accepted for adoption in the first weeks of life. They should not be placed in insti-

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tutions or other foster homes for a period of observation and "preparation". Changes in foster homes or any other radical changes which sever all relationships should be avoided for children under school age. Children who have had any of these experiences should not be considered adoptable until they have reached school age and have shown normal personality development and school adjustment. The care and treatment of such children, once the psychopathic personality defect is established, should not be therapeutic, corrective or punitive: it should be protective and should aim to foster a dependent relationship.

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PROBLEMS OF PATIENT-THERAPIST RELATIONSHIP IN THE TREATMENT OF PSYCHOPATHS

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It is a principle of treatment that the therapist must understand the pathology of the maladies of his patients if he wishes his treatment to bring results beyond the temporary and sometimes superficial ones of symptomatic improvement. In illnesses of a psychiatric nature this is particularly striking. Temporary improvement in symptoms is, in many instances, not difficult to effect through suggestion, whether this is administered directly in hypnotism, persuasion, the giving of placebos, or in any of the many indirect forms familiar to psychotherapists. While such symptomatic improvement may be dramatic and sometimes valuable, it generally breaks down again unless it permits at the same time the beginning of more fundamental changes. If such a therapeutic breakdown occurs, this fact in itself becomes an element of discouragement to both patient and therapist and may thus later even be an obstacle to further or other therapeutic efforts.

All of this is quite conspicuous in the handling and treatment of psychopaths: very often they make quick dramatic improvements which are soon revealed to be only 'skin deep' or to disappear as dramatically as they were instituted; it is then apparent that the fundamentally unsound organization of the personality of the psychopath has not been much influenced or even touched.

In considering the defects of the psychopathic personality structure, we may focus on three aspects of its deformation: (1) the primitive drives or instincts and their derivatives, (2) the sense of self, and (3) the conscience. Although the psychopath's obvious behavior disturbances, especially his excessive and impulsive indulgences, appear as though he were com-

pletely at the mercy of unbridled instincts, there is little or no evidence that these drives are in themselves markedly increased or congenitally deformed. Their apparent strength and disturbance is due rather to inadequate control, check, or direction of the primitive biological forces. The real trouble seems to lie more in the sense of self (ego) and in the conscience (superego) development. Because of defect in both these areas of his personality, the psychopath characteristically has very poor self-critique, poor—*i. e.* intense but shallow—relationships to other human beings, inadequate and inconsistent control of impulses, and very unrealistic estimates of his own abilities. He is often open to immediate suggestion, but none the less tends to be over-assertive about his independence and to be either too optimistic about or too depreciative of his own capacities and ideals.

It has long been recognized that much of the pathological development of the psychopath's personality is traceable to the poor relationships between parents and child earlier in life, and that the results of these inadequate relationships are multiplied when the young adult is expected to fend for himself. The world then takes the place, in large measure, of the parents. The 'bad' behavior of the psychopath consists in the attempts of the individual to use on the world those methods which have previously been effective with the parents or those in *loco parentis*. This situation naturally becomes increasingly complicated as society takes progressively more retributive action towards the psychopath's antics, and frequently ends by placing him in a hospital or a penal institution. Here, too often, he is held rather than treated, and is discharged after he has calmed down and made promises about his future behavior very much as a bad child returns to favor after being banished to his room for a time.

Although it is very valuable and perhaps essential in the handling of psychopaths that the therapist understand the unique dynamics of the character development in each case, this

paper is not devoted to the study of the pathology in itself,* but rather to the general problems of relationship between therapist and patient occurring in the course of treatment. While there are some behavior disorders which are primarily neurotic and based in large measure on the influences of early emotional traumata, these form a relatively small group comprising such conditions as compulsive stealing or compulsive lying, certain conditions of fetishism, and some states of perversion, and need not be confused with the polysymptomatic psychopathic states. They resemble the latter chiefly in that, in both instances, the symptoms are acted out in an anti-social form. The psychopath generally cannot be psychanalyzed; the patient suffering from neurotic behavior disorders sometimes can be.

From what has already been presented it follows that the therapist's position in relation to his psychopath patient is even more than ordinarily endowed with the problems reflected from the earlier parent-child relationship of the patient, with its mixture of expectation, of sharp disappointment and its hope of supreme indulgent gratification. The therapist who keeps this constantly in mind in his handling of psychopaths will himself be less disappointed and can more readily develop the enduring patience which prevents him from seeing his patient's behavior too exclusively in relation to himself, even when it seems at the time to be so motivated. The long range goals of treatment are essentially the development in the patient of a better sense of reality and a more useful conscience, this latter including both realistic self-critique and durable, rather than fancy, ideals. A primary requirement of such fundamental growth is *time*. Consequently, the therapist himself must be prepared to give this, not so much in a series of single allotment, but actually extending over a long period. In other words, the treatment of psychopaths cannot be expected to be even modestly successful unless the therapist is sufficiently in-

*I have gone into my ideas of the psychodynamics in a certain group of psychopaths in an article, "The Conscience of the Psychopath" to be published shortly in the *Amer. J. Orthopsychiat.* This article also contains a brief summary of some of the literature.

terested to carry through for months or years. These patients are not generally cases for short psychotherapy. In private practice this need for time is one of the severest obstacles to good treatment, as the patient so readily runs away from treatment and an overly optimistic therapist is too readily satisfied with token improvement. There is, therefore, a definite advantage, on this score at any rate, in institutional treatment with the initial commitment of such patients. Unfortunately, however, at present the institutions provided are usually either prisons or hospitals for psychotic patients, neither of which is generally suitable for the continued treatment of psychopaths.

There are two aspects of the disturbed sense of reality in the patient that should be especially considered here: (1) the failure to establish early in life any adequate process of reality testing, with consequent disturbance in a good appreciation of cause-and-effect, and (2) the increased expectation of getting results by magic rather than by effort.

The failure to develop a good sense of cause and effect is generally due to the early insecurity or actual lack of an emotional relationship to the parents, and at the same time an inconsistency in the practical attitudes of the parents toward the young child. Thus, what 'works' for the child at one time completely fails at another. The factor of parental inconsistency may have been further increased in those cases where the patient has been shuttled back and forth among a number of 'parental' relatives, and has inevitably developed an attitude of opportunism in place of a sustained relationship. If the early emotional deprivation has been extreme, the patient may, in his later relationships to the therapist, be at first suspicious and hostile, and then overwhelmingly attached and obedient, with a genuine rather than opportunistic need to please, which may become burdensome to the therapist unless it is understood and skillfully re-directed. Throughout, fairness and consistency—especially in the utilization of natural consequences—are of the greatest importance. If the patient is to build up new and more practical ideals than those he has already achieved, he will do so not only, and perhaps not so

much, through discussions with the therapist as in appreciation of the way he is handled in other respects. The fact that office treatment of psychopaths does not permit of this spread of therapeutic contact may be an important reason for its failure and general unsuitability.

The increased demand for results by magic (so evident symptomatically in the psychopath's willingness to take a chance, and in his expectation of good luck or his blaming of bad luck) seems partly a persistence of a universal infantile quality, but one which had become further exaggerated and even nurtured by the inconsistency of his earlier handling. Results *have* actually seemed to come by divine chance (of parental whim) early in life, or to have been elicited by ingratiation rather than by work. The reliance on magic is perhaps most striking in the verbalism of many psychopaths who later in life seem really to expect accomplishment through the magic of talk rather than through any sort of action; and who seem actually to confuse the symbol and the gesture with the accomplished deed (semantic dementia of Cleckley). The reduction of this demand for magic or its negative counterpart, the over-readiness to find excuse for failure, is one of the most difficult tasks of therapy. It appears to diminish insofar as a system of reality-testing is established. It may enter into the patient-therapist relationship, however, rather subtly and destructively, unless the therapist is himself alert to its danger and is self-critical. The therapist readily becomes to the patient a quasi-magic figure, whose abilities and attributes are pleasantly magnified to the patient, and whom he consequently indirectly flatters or placates especially with seeming improvement, or in other indirect ways. The inexperienced therapist, one who has not himself developed a firm self-appraisal, may be unwittingly tricked by the seeming quick success of his treatment, and then as time goes on become increasingly cynical. Insofar as this occurs, he becomes slightly infected by the patient's outlook, rather than realizing that the successful foundation of new ideals in the patient depends in some measure on the patient's unconscious use of the therapist as a model,

and that this goes on gradually, extending over the entire time of their mutual contact.

In general, it may be said that in treating psychopaths, almost more than with any other group of patients, it is necessary for the therapist to know and to study the relationship between the patient and his parents (or those who served in their stead) in his *early* childhood; *i. e.*, at the time when the sense of self and the conscience were developing, in order to understand what will be the nature of the emotional attitudes and expectations put upon the therapist. Only so can he suit his treatment to the real, rather than apparent, needs of his patient. It is absolutely essential that the therapist be able to give to his patient time, patience, and understanding, and that he should have sufficient liking for his patient to want really to help him rather than predominantly to coerce or to punish him.

BASIC CONSIDERATIONS OF THE CONCEPT OF PSYCHOPATHIC PERSONALITY

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Considerable controversy exists in the literature and among practicing psychiatrists as to whether the term, "psychopathic personality", represents a well-defined psychopathologic concept, or whether it is merely used for practical convenience. No definition which is generally acceptable has been offered. A basic discussion, therefore, seems indicated; one unhampered by the practical and legal considerations of how to handle an individual presenting social difficulties. In any fundamental study one must take into account the mild cases which usually are not brought to the attention of the psychiatrist but are well known to any physician who is interested not merely in his individual patients but in their family relationships as well. In the small sociological unit of the family in which self-restraint is most readily relaxed, personality maladjustments which may not be demonstrable in contact with society may become obvious.

It is most unfortunate that in the public mind the term, "psychopathic personality", so frequently connotes a person who is "bad" or "weak willed". Too much stress has been placed on the legal aspects and social difficulties. Very often a diagnosis is made entirely by exclusion; *i. e.*, whenever an individual who is poorly adjusted socially cannot be classified under one of the well-recognized patterns of the psychoneuroses or psychoses he is diagnosed psychopathic. It is obvious that physicians should work with psychopathologic reaction patterns which are well described and can be recognized by any well trained observer whose personal bias should not be permitted to act as a guiding principle.

The essential features in this behavior disorder are insuf-

ficient self-reliance and unsatisfactory adjustment to the group in which these persons live. Their psychopathologic manifestations cannot be explained by the existence of any of the well-defined personality disorders. This clinical observation is the justification for the concept of psychopathic personality which, as the term indicates, embraces a large and varied group of maladjustments. It is to be expected that with the progress of psychiatric knowledge, definite types will be singled out and separated from the present heterogeneous group. Some investigators have succeeded in futhering a genetic-dynamic understanding of such personalities. Psychoanalytic research work has pointed to fundamental factors in the development of these personalities and has stressed the importance of earliest childhood experiences. These observations, although applicable to many of the patients, cannot explain all types. A careful study of psychopathic personalities will reveal that some are definitely of a psychoneurotic type in which the social maladjustment is of such a degree that the diagnosis of psychopathic personality is indicated. Electroencephalographic studies have pointed to the existence of some well-defined types in which neurophysiologic components play a role. Previously accepted factors of heredity, which led to constitutional groupings, after critical scrutiny could not be maintained in their original form. The presence of psychoneurotic reactions does not explain the whole disorder on a psychoneurotic basis nor does the presence of constitutional factors or a special type of heredity force one to accept a constitutional etiology. The tendency of psychiatrists to establish a relationship between psychopathic personalities and classifiable psychiatric illnesses has led to much confusion. Terms such as "schizoid", "heboid", "cyclic", "epileptoid", "hysterical", and "compulsive psychopath" give the impression that one deals with mild degrees, or forerunners, of psychiatric illnesses. This terminology was based on superficial comparison rather than on sound psychopathologic study and consideration. Later, when their medical usage had been established, these terms were applied

by many critical persons who would have rejected them originally.'

If one considers psychopathic personality the expression of psychopathologic changes in a psychobiologically integrated individual, it seems sound to make the psychopathology of the personality the fundamental issue. The functions of the personality may become pathologic when the organization of the personality is disordered or when personality features are exaggerated or underdeveloped. This conception of psychopathology corresponds closely to that of pathology; *i. e.*, findings which are unusual in degree, or occur within the wrong age period, are pathological.

The grouping of psychopathic personalities will always be artificial because maladjustment may exist along many lines as will be seen from the types which are discussed below. It is important that one be guided by careful psychopathologic evaluation. The degree of malfunctioning has to be such that it is indisputably outside the average. Otherwise many personality difficulties and undesirable features will be designated psychopathic instead of being recognized as individual variations of behavior which are not pathologic, even though psychotherapeutic adjustment may be indicated.

In disorders of the organization of the personality, late or insufficient maturing may be the essential factor as seen in the immature psychopath. In another type; *i. e.*, the loosely organized psychopath, the functions relating to the synthesis of the personality are disturbed. In both types, we find a lack of need and ability for the spontaneous adjustment of contradictory strivings and acts. With immaturity, which occurs in early as well as later adolescence and in adults, the person's attitude to life and his judgment in general do not correspond to his intelligence and chronological age. In a third type, one detects a lack of plasticity of the personality which may be the essential maladjustment or merely one symptom of a poorly organized personality.

It is difficult to group psychopathic personalities on the basis of the psychopathology of various personality functions.

BASIC CONSIDERATION OF THE CONCEPT

Individual practioners may disagree, each stressing different aspects. The groupings are not important as long as one adheres to the psychopathologic principles discussed above. Following an outline for studying normal personalities, this author makes use of subdivisions which have proved useful to him. A brief discussion of these may be stimulating to the reader. The categories are selected from a practical point of view; they are artificial and overlap at some points. Different or additional subdivisions may be found more practical by others. The subdivisions are: 1) intellectual resources, 2) emotional tendencies and temperament, 3) volitional and action tendencies; interests and strivings, 4) standards, 5) attitude to one's own body and to the instinctive desires, 6) attitude to material needs, 7) attitude toward oneself and ability to deal with oneself, and 8) social needs and adjustment to the group. Some psychopathic personalities may have a basic but usually unrecognized intellectual disorder. In these patients, one finds vague thinking caused by poor concept formation. The symptoms increase under the influence of intense emotions, especially those of anxiety and anger. These difficulties may occur in the setting of an adequate or high intelligence. The psychopathologic reactions in the emotional field include the pathologically moody person, the person with poor control of excessive emotional reactions, as well as the emotionally dull person. In the volitional field a lack of initiative or of persistence in pursuing goals may be noticeable, or a discrepancy between ability and ambition may lead to chronic discontent or resentment to life. The best-known, but by no means the most frequent, group consists of persons with low ethical standards accompanied by the resulting social difficulties. This antisocial and asocial behavior is seen in irresponsibility with disregard of consequences, lack of persistence of emotional relationships, and lack of emotional depth (Greenacre). Inability to profit from experience leads to repeated misdemeanors such as stealing, untruthfulness, truancy, and irresponsibility with regard to social and financial obligations. Exaggerated ethical standards are seen in fanatics and querulous types. Dif-

ficulty in controlling instinctive desires is of importance in many sexual perversions. General inadequacy and insufficient self-reliance, frequently accompanied by incomplete emancipation from one's family or cultural background, illustrate other psychopathic difficulties. In some, there may be a faulty attitude to the group—a lack of belonging, a lack of the need to share with others, and a lack of feeling with others leading to callous or even cruel acts; a tendency to look for indications of disparagement, pathological degrees of aggression, and a rebellious and antagonistic attitude.

The presence of several of these pathologic personality reactions, in the setting of a more or less marked disturbance of personality organization, will result in a great variety of clinical pictures. This variability should argue against rigid systems of classification and uniform etiological explanations. It does not argue against the psychopathologic concept of psychopathic personality.

It is important to recognize the self-evident fact that psychopathic maladjustments may be of mild as well as severe degree, and that the influence of aging may produce considerable changes in the stability of the personality and in its behavioristic expressions. Psychopathic personalities of mild degree may not be recognized in daily life where favorable social considerations exist, whereas they become more obvious under unfavorable situations. It is necessary to evaluate the individual problem in order to determine whether or not the psychopathologic difficulty has improved under changing conditions. Few facts are known with regard to aging. In young adolescents, spite reactions are frequently included in the psychopathic group, whereas closer investigation reveals that they are of a psychoneurotic nature. Delayed maturing (*i. e.*, after from 20 to 22 years of age) may be the recovery process of psychopathic personality or of a well-defined psychoneurosis. During adult life, with the subsiding of instinctual desires, and also when a decrease of ambition occurs, many psychopathic difficulties may disappear. It is not known whether this cessation of symptoms is accompanied by a reorganization

of the personality or whether no essential change of the total personality occurs. Without prolonged, intensive study of the individual patient, it cannot be determined whether psychopathic behavior is based on neurotic development or whether one deals essentially with a disturbance of the personality structure. The presence of anxiety as an essential factor is often overlooked, especially in delinquency.

Prognostic evaluations are possible only if one considers the individual case, paying attention to the factors which permitted periods, or at least episodes, of success in life as well as those which caused difficulties. Even then, prognostication will remain hazardous until more is known about the dynamic factors of these psychopathologic reactions. In present day medical literature, there is still a paucity of factual data offering the possibility of analysis and evaluation by others. General statements, often combined with dogmatic theoretical inferences, have been made the basis of many prognostications which affected the patient's life. Often, relatives and members of social groups will tolerate an undue amount of psychopathologic behavior. When a psychopathic patient is brought to a physician the facts presented by such informants may sound far less serious than if coming from another environment. The experience in our armed forces has demonstrated this in a considerable number of psychopaths. Such patients may have reacted to unacceptable social factors in army life with an aggravation of their psychopathic difficulties. With removal to a previous, more acceptable life, the symptoms subsided again. The same observation has been recognized in civilians in whom similar results are produced by changing socio-economic factors. However, it is also possible that a patient does not react with an aggravation of symptoms to life in the army but his behavior, which had been acceptable to his own group, is considered pathological in the new setting. From my experience in the Rehabilitation Service of The New York Hospital, such patients, although no change in behavior has occurred, may be accepted again by their groups and considered recovered.

Treatment must be regarded as an individual problem. Inadequate facilities and a dearth of well-trained physicians may make it impossible for a long time to offer satisfactory treatment to all these patients. It is therefore important that carefully documented therapeutic studies be made available and that new methods which may be less time-consuming be sought. There are two extremes to which physicians have gone. On the one hand, undue psychotherapeutic effort has been expended on selected cases because the psychiatrist treated the patient's psychoneurotic symptoms or carried out an intensive and prolonged personality analysis because he was not able to evaluate the psychopathology of the whole personality. The results of this type of treatment are unsatisfactory. Probably everyone who has carried out intensive psychotherapy over a period of many years has experienced such disappointments. On the other extreme are the psychiatrists who have a discouraged attitude and try to correct the patient's maladjustment by disciplinary methods which they often mistakenly consider to be psychotherapeutic reeducation. The best guidance for those who wish to carry out intensive therapy is the need to offer an active psychotherapy in which the personal analysis is combined with reeducation. In most cases reeducation, based on the understanding of the individual personality, is of utmost importance. In only a small minority will reeducation become the adjunct to psychotherapy. This group consists of psychopaths whose maladjustment is due to psychoneuroses. Psychotherapy which is not accompanied by active help from the physician is contraindicated in psychopathic personalities. The reason for these therapeutic indications and contraindications is that the personality is usually too loosely integrated to achieve a spontaneous therapeutic synthesis. Environmental difficulties lead to repetitious emotional involvement which interferes with treatment. The frequent repetition of emotional reactions to similar situations facilitates the occurrence of the emotion.

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An important therapeutic point which should warrant critical optimism is the fact that every psychopathic individual has inherent potentialities which permit him to function adequately, if not successfully, if the right situation in life can be found for him. This statement is sufficiently qualified to make it seem futile. The life histories of many severe psychopaths demonstrate, however, that there may occur unusual situations permitting a successful solution for such persons. Without a basic optimism, combined with a willingness to look for unusual possibilities of adjustment and the utilization of unexpected opportunities, treatment becomes disheartening. It is questionable whether any psychiatrist can devote his life exclusively to the treatment of psychopathic personalities without becoming stale in individual therapy. Some physicians may find a constructive outlet in working out broad principles of guidance and administrative problems. Others become discouraged disciplinarians. A possible correction of this undesirable development might evolve if these physicians also saw other types of personality disorders in which they might find encouraging results and thereby participate in a broad way in the progress of psychotherapy.

In using reeducation, based on a constructive analysis of the personality, "one should be guided by the fact that every person has features with which we can work and that a more or less suitable situation should be created. Perfect results cannot be expected and relapses should not discourage. The physician should be guided by what he considers essential and give in only on non-essential points. The patient needs to understand that certain undesirable reactions will produce reactions from his environment which are undesirable to him and that sympathy and pity will not modify the attitude of others. He has to become self-dependent and recognize the need to adapt to life. His constitutional deficiency is not an excuse but a handicap." (*Treatment in Psychiatry*, p. 395)

Whenever possible, it is desirable that patients be treated while they are leading an active life and are self-supporting. In the excitable types who may react with dangerous outbursts

of anger, attempts at suicide, and psychogenic deliria or stupor, hospital treatment is necessary. Certain social maladjustments and criminal acts make institutional treatment mandatory. If persistent efforts at readjustment have failed, or if the patient is considered a suicidal or homicidal risk, a brief period of hospitalization is indicated. In the antisocial and asocial group, despite the fact that prolonged treatment over a period of years in a psychiatric hospital may prove to be futile, it should always be tried. The patient should understand at discharge that he will be immediately readmitted if any misdemeanors occur. This policy corresponds to the advice given a patient when he leaves any other type of hospital; the suggestion that he return in case of a relapse. In medical thinking, the use of threats is avoided and the patient should be made to understand his physician's reasoning. It is very doubtful whether it is desirable to have hospitals exclusively for psychopathic patients. This type of hospital creates a group atmosphere which might undo the beneficial results of individual psychotherapy. It has not yet been proved that group psychotherapy or wise management may overcome these undesirable features. From a theoretical point of view, psychopathic personalities should always be treated in a psychiatric hospital, grouped with other kinds of psychiatric disorders. The treatment of special types of psychiatric illnesses in special types of hospitals will always be accompanied by many handicaps.

The medical attitude should not be set, yet it must also avoid leniency which the patient may abuse. The physician must be aware of the constantly changing patient-physician relationship. He has to recognize the patient's emotional reactions and attitudes to him. In the treatment of psychopathic personalities, the physician should scrutinize his own feelings most carefully. The patient's misbehavior, his spite and resentment reactions, his desire for affection, his appreciation of what is done for him; all these and many other emotional reactions involve the physician's emotions in a very complicated and frequently quite unclear way. Successful treatment and guidance depends on the physician's ability to observe and un-

derstand himself. The same factors may enter into the patient's relationship with nurses, who should be able to understand themselves if they want to be helpful.

Psychotherapy should be directed toward the establishment of self-reliance and the ability to become part of the group in which the patient lives. A healthy life should include attention to one's physical and psychological needs, suitable work, and recreation. A constructive analysis of one's personal development and an understanding of the factors which played a role in one's successes and failures will offer the necessary material for readjustment. The manipulation of social factors will have to be considered in each individual case. An understanding of how to handle one's reactions to life will offer guidance. The experienced physician will adjust these general principles of psychotherapy to suit the individual case, selecting the most promising psychotherapeutic methods.

In a survey of the patients admitted to the Payne Whitney Psychiatric Clinic, it was possible to single out some patients of an age over 45 years whose lives represented that of a psychopath until about 30. These patients might be considered recovered psychopaths who were admitted years later for quite different psychopathologic reactions, such as depressions and cerebral arteriosclerotic manifestations. In some of these patients, we dealt with psychopathic personalities of the psychoneurotic type. By finding a suitable life situation (*e. g.*, marriage or suitable working conditions) these patients began to lead normal and successful lives. In most instances, however, their personalities were precariously balanced. Others, while appearing well, became psychopathologically disturbed when previous guilt feelings were stirred up or when anxiety-evoking situations occurred. These cases should be distinguished from those who merely adjusted socially or in work. The psychopath who manages to lead a successful life because his particular type of psychopathologic difficulty does not interfere is an example of what might be achieved in other cases through medical aid.

The fact that a suitable marriage may permit some psychopaths to lead a more successful life than otherwise should

not induce physicians to consider marriage as a means of adjusting a patient. Such marriages may be successful because the patient has found a partner who fills some psychopathologic need. The inadequate person may find the necessary support in a motherly woman, the vascillating type in a competent person. A person who is disturbed by homosexual strivings and by other sexual maladjustments may find sexual security. These examples are very superficial. They demonstrate that such beneficial marriages are possible, but that husband and wife would have to be analyzed most carefully to show the psycho-dynamic factors involved. Such a study would result in destroying what has been made constructive by the utilization of psychopathologic factors. No physician is, therefore, able to state in what way such a marriage could be predicted to be a success.

The psychopathology of psychopathic personalities offers a fruitful field of investigation which will further our knowledge of individual and social pathology. Treatment can and should be carried out optimistically if one is able and willing to recognize the indications and contraindications for different types of therapy. One should be willing to accept the fact that physicians can never treat successfully all of the patients suffering from the same illness. According to the present stage of medical progress a limited number can be helped a great deal, others to some extent, and still others very little, if at all. One's hope is that with increased knowledge, those who can be treated successfully will grow in number. The longer a maladjustment has endured or the more ingrained habits have become, the less amenable is the disorder to correction. These principles apply to all physical and personality disorders. The inclusion of social factors does not prevent their application to the psychopathic personality. A combination of sound biological, medical, psychiatric, and sociological thinking is necessary for the solution of this problem.

THE PSYCHOPATH VIEWED PRACTICALLY

HERVEY CLECKLEY, M.D.

Nowhere in the field of psychiatry is there such an evasion of practical issues as in our dealings with the so-called psychopath. The term itself is, one might say, professional slang, an abbreviation or nickname for a particular group of patients who, in formal correctness, fall in the official category of *Psychopathic Personality*.⁵ The term is seldom if ever used to denote all that one finds listed in this category since it strongly implies a restriction to only one of these several and quite different types. If a psychiatrist, in speaking to another about a patient, uses the term *psychopath*, there is seldom any misunderstanding as to the sort of patient in question. How such patients will behave is common knowledge to all who have known them. Few psychiatrists, informally and among themselves, ever use *psychopath* if they refer to patients whose personality difficulties are predominantly schizoid or cyclothymic or whose problems consist primarily in a well-defined sexual deviation such as homoeroticism. What the average psychiatrist means by *psychopath* is a remarkably definite type of patient who, at the clinical level of behavior, can be readily distinguished from all the other types listed with him, presumably as similar, or at the least as definitely allied, in our technical scheme for the classification of mental disorders.

If, then, there is this distinct and generally recognized type of personality disorder, why should it be shuffled up in a broad and vague diagnostic group with numerous other disorders? Certainly little can be said for the practicality of such an arrangement. If one attempts to discuss this type of patient and uses the approved term *psychopathic personality* he finds it difficult to be either clear or accurate. What one says will have little connection with the other conditions to which the term also applies. When plans for treatment are consid-

ered or changes suggested by psychiatrists in regard to the status of such patients in the courts, deep confusion is sure to arise if it is assumed that all the other classes of patients in this heterogeneous group are included. As matters stand, it is difficult for the author of a textbook to present a common and extremely serious type of disorder so that the ordinary medical student can get a fair idea of the subject. The subject is all but lost in the effort to carry along these several other irrelevant entities, falsely but officially wedded in the classification. In presenting the psychopath, one labors under a handicap not altogether unlike the handicap which would confront a medical writer who attempted to discuss leukemia if this term also meant a broken leg, a brain tumor, and the common cold; and if there were no other term available.

Psychiatrists, it is true, soon learn by experience to recognize the psychopath. The writer would have difficulty in recalling any colleague who fails to distinguish the sort of patient indicated when this term is used. There is nothing vague about such patients if one considers their behavior. Far more than for the orthodoxly psychotic, their course of conduct can be predicted and the succession of troubles before them foreseen. The very word *psychopath*, then, serves in fact not only as an abbreviation for the cumbersome official term but, whether this is consciously admitted or not, implies, among ordinary psychiatrists, not all those conditions listed under *Psychopathic Personality* but precisely one type who in their persistent and highly characteristic abnormalities constitute a distinct entity. Ordinary usage among those who deal directly with such patients has already provided, then, a means of discarding some of the ambiguity and confusion written into the sanctioned standards. This, however, is not enough; for when the final diagnosis is written or questions of competency or commitment are faced, the word *psychopath* disappears and the formal term, with all its false assumptions, returns and makes sensible action difficult if not impossible.

From a historical point of view, it seems probable that the type of patients usually referred to as psychopaths were grouped

with many other diverse types under a single diagnostic classification because of a fancied similarity in the degree of deviation from a normal or sane standard. The writer maintains that neither in fact nor in theory can this allocation of the psychopath to a position regarded as borderline or equivocal be justified. From the standpoint of practicality it is therefore suggested: (1) that this group of patients be considered separately and entirely on the basis of what they prove themselves to be, and not along with others and by attributes of these other groups that they do not necessarily share; (2) that the patients of this group be quantitatively judged on the degree of disorder or deviation they themselves manifest in the conduct of life and on this alone, instead of being legally and medically pronounced sane and competent because of a traditional term, still officially sanctioned, but which neither distinguishes them nor qualifies them in any useful way.

Of what practical importance, one may ask, is it to change the name we have given to a disorder? Why should we waste time and energy debating about where a group of psychiatric patients is to be placed in our verbal system of classification? At first glance, it does indeed seem trivial, if not useless or even regressive, to discuss the matter instead of turning immediately to such questions as the nature, the cause and the possible cure of the disorder. There are, however, excellent reasons for insisting that such a change should be made promptly, and that this simple measure would do more to help society in its problems with the psychopath than all others proposed to date.

First of all this change would make it possible for such patients to receive medical care. Astonishing as it may seem to the layman and to many physicians, this large group of seriously ill and disordered human beings cannot—and we all know this—be treated at all under our present system. In the light of recent campaigns to bring better medical services to the poor, it is surprising that so little interest can be raised in the fact that a large and important class of patients are prevented from

receiving any medical attention at all. Yet it is a fact and unadorned.

The patient with pneumonia or a broken arm spontaneously seeks help from his physician and is not refused. The unconscious victim of cerebral trauma is taken by his family or friends to a hospital where attention is forthcoming. Cases that we classify as psychoneurotic can, in general, be trusted to go to the psychiatrist if their symptoms are sufficiently troublesome; or their relatives have at least a fighting chance of persuading them to do so. Other patients, judged by our present standards as psychotic, seldom if ever recognize the need for treatment. Often by legal authority and sometimes by physical force, they must be placed against their wishes in psychiatric hospitals. This, however, is a well recognized fact. Medical opinion and practice, legal instrumentalities, and considerable understanding on the part of the psychotic patient's relatives, all work together, and institutions provided by society accept responsibility for treating the patient and are empowered to hold him as long as necessary for his own welfare and safety and for the protection of others.

In turning to consider the patients usually spoken of as psychopaths, we find an arresting contrast. They do not voluntarily seek medical treatment; for, like the schizophrenic, they have no genuine or practical awareness of illness, however serious their condition. In fact, and again like the schizophrenic, the greater or the more dangerous the degree of their disorder, the less likely are they to realize or be persuaded that they need help or supervision. Some may disagree and challenge this opinion by citing psychopaths who admit that they have something wrong with them, or others who agree to take psychiatric treatment and even consent to enter closed hospitals. The writer also has seen many such cases. It is firmly maintained, nevertheless, that the psychopath does not in any significant sense realize his disorder. His admission that he is mentally ill is of no more practical moment, however convincingly he may express it, than the reply an intensely psychotic manic patient recently made to me. This man had torn his shirt to shreds and,

half-clad, was playing with live wires he had exposed, apparently relishing the ordinarily painful effect of the electricity as he voiced his claims of being a millionaire, a satyr, and a messiah. When asked if there was anything wrong with his mind, he shouted enthusiastically, "Of course, Doc! I'm nuts! Just plain nuts! I tell you I'm crazy as Hell." An equally impressive example of this merely verbal "insight" is furnished by a deeply regressed schizophrenic who, after many years on a closed ward, still frequently calls out to passers-by, "Simple case of dementia praecox, Doc! Simple case of dementia praecox!" Despite the truth of his statement, which he reiterates while pointing to himself, and despite even his chance diagnostic accuracy, no layman, much less a psychiatrist, who knew this patient, would be convinced that his words indicate the slightest real understanding of his own condition. To maintain that they do indicate this would merely be to strip the word *understanding* of all that it signifies.

If we estimate the psychopath, as all of us indeed estimate the two men just mentioned, by his behavior, by the objective demonstrations he gives of understanding, we are forced to conclude that from a practical standpoint at least, he appraises himself no more correctly than these other obviously psychotic cases. It is true that he can sometimes be persuaded by his relatives to consult a psychiatrist, but it is equally true that he shows no real interest or anything but the mimicry of cooperation in treatment. Nearly always some external means of coercion is necessary to make him even go through the form of maintaining a medical relationship. The threat of cutting off his financial support, of bringing suit against him for his misdeeds, or of allowing him to remain in jail, may move him to visit a physician's office or even to enter a hospital, but subsequent events show that he is acting, not seriously and with the understanding he professes, but for the purposes of evasion, whether he himself realizes this or not. He breaks off his treatment as soon as the evasion has been accomplished and even while he is pretending, perhaps unconsciously, to seek help, one soon realizes that no serious conviction or intention

lies behind what he displays and means to have taken as his cooperation.

In attempting to carry out therapy with such patients, I have never failed, soon or late, to have it dawn upon me that I was participating in something not free from farce. In therapeutic relations with them, one invariably comes to feel himself in the position of a school teacher attempting, however tactfully or subtly, to influence a class of incorrigibly mischievous and irresponsible children who, though they sit for the moment quietly and apparently at attention and seem to be in dead earnest about the subject, are even now totally absorbed within by thoughts of where to throw the spitballs they are rolling under the desks as soon as the teacher turns her head; and by larger plans to disconnect the steampipe from the radiator, break out the window panes, defecate on the floor and set the school house on fire if she for one moment steps out of the room. These children are not so much antagonistic as indifferent to all the teacher says. Whether teacher is psychiatrist or the whole of life at social and humanly personal levels, it is the same.

Only under strong coercive forces will the psychopath allow himself to be placed in a psychiatric institution. And regularly he shows his unawareness that he is disordered and in need of treatment by taking steps to secure his release. The psychopath, most physicians who have tried to deal with him will agree, like the seriously disordered manic or schizophrenic, will have to be constrained against his own volition to have medical treatment or supervision if he is to have these things at all. While our present system of classification remains, it will continue impossible to handle these patients on a medical basis.

Though our laws provide for the commitment of persons whose mental illness is so severe as to deprive them of good judgment, we as psychiatrists have arranged a scheme of terminology whereby a far from negligible group of patients are automatically classified as sane and therefore presumably of

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adequate judgment. No matter how grossly and persistently such patients show themselves incompetent, in all ordinary or practical senses of the word, few psychiatrists today will dare state frankly in court that psychopaths are psychotic and incapable of deciding for themselves whether or not they need treatment and supervision. Even on those rare occasions when the psychiatrist decides to defy the verbal impediments we have placed in the way of common sense measures, and admits that the patient has proved himself thoroughly incompetent and is likely to remain so, little is accomplished; for most public institutions will either refuse him admittance or, with no change at all having occurred in his condition, soon pronounce him sane and competent and discharge him.

The writer would not be reluctant to admit that new legal concepts and new laws are needed for us to deal adequately, or even sensibly, with many of the problems that continually arise concerning competency, legal responsibility, and degrees of culpability, impaired judgment and self-control. In most states, the law, at least theoretically, operates on the assumption of an absolute contrast, an *either-or* standard by which one must pronounce patients totally insane (irresponsible) or totally sane (responsible).⁴ This, as nearly all psychiatrists will admit, is neither in accordance with reality nor conducive to fair or useful action.³ Without minimizing the need and the urgency for basic changes that might be made by those who formulate our laws, the writer would like to stress the fact that, however antiquated and unsatisfactory our laws may be, they are sufficient for us to put a stop to the farce and tragedy that regularly characterize our efforts to deal with these patients we call psychopaths. This could be done promptly by admitting that the type of disorder we see in these patients varies like the other disorders we call schizoid or cyclothymic from a degree constituting mild or moderate disability to a degree constituting incompetency and making supervision necessary.

There are several factors that probably influence us against taking this important step. Formerly, mental disorder, to be recognized and so classified, had to be obvious if not

spectacular. One hundred years ago a diagnosis of "insanity" would no doubt have been agreed on for the paretic who ran naked one fine morning through the streets, proclaiming himself as the Holy Ghost, and for the schizophrenic who grimaced and smiled inanely while smearing his face with feces and explaining that the Archangel Michael had instructed him to amputate his penis. So, too, with the manic, who, after years of demure spinsterhood, decked and painted herself like a harlot and pranced into the village church whistling, winking, chuckling, shouting one moment for all men to come and partake of her body, and the next, for all to repent of their sins, meanwhile singing enthusiastically snatches of songs between further remarks on the weather, the shape of the clergyman's nose, and the atrocious color of a neighbor's gown.

These people would no doubt have been recognized at that date as mentally disordered and not in the ordinary sense responsible for their behavior. A century or two earlier, it is not unlikely that such goings on might have been attributed to witches or demons and the victims themselves burned to death, or on the other hand revered as holy manifestations of God and indications of salvation. One hundred years ago, though pronounced insane, little distinction would have been made among the types of disorder.

As medical practitioners have continued to work with personality disorder, clearer distinctions have been made between types of such illness, and less obvious types have been recognized. Some of these less obvious types are fully as serious as the most bizarre. The layman perceives the disability of the tremulous fellow who shouts that wild boars and huge bugs, five feet long, are after him, and who springs over his hospital bed to escape them. Even the experienced physician may, however, overlook the presence of illness in an early case of paranoid schizophrenia. Yet the second patient is almost immeasurably more deeply damaged than the first. Even today, one encounters many people who find it hard to believe that "anything could be wrong with his mind" if a patient is in good touch with his surroundings.

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Within the last week a patient's relatives expressed to me the opinion that "it couldn't be his mind" though they admitted he said dead people were talking to him incessantly.

"I don't see how you can say he's lost his mind," the man's daughter insisted, "because he knows all of us and can tell you anything he reads and even add up the figures in the books at his store without making a single mistake."

The layman, even today, in seeking to determine whether real mental derangement exists often depends largely on such manifestations as obvious confusion, delirium, or a general inability to reason. All psychiatrists today realize that a considerable percentage of the most gravely disordered cases maintain excellent contact with their surroundings and can sometimes reason with exquisite logic. Though psychiatrists in this respect are in advance of the laity, one cannot escape the conviction that psychiatry also lags in the direction of traditional criteria. The layman often demands deep confusion, illogical conclusions on most subjects, or obviously bizarre behavior to fulfill his idea of a "crazy man". Psychiatry, also, in its official standards, demands certain technical points and sticks to them with amazing dogmatism, regardless of the patient's almost incredible demonstrations of his disability. On the other hand, a patient with clear-cut delusions or with hallucinations is likely to be pronounced psychotic, even though he conducts himself circumspectly and causes no damage to others or to himself.

A thirty-five year old male patient recently studied by the writer illustrates our point. During the psychiatric examination this man freely admitted that for more than fifteen years he had been hearing voices that spoke to him during the greater part of every day. He was genuinely convinced that the voices were objectively real and coming from inimical persons, though he could not name them or explain why they chose so to harass him. During an examination for induction into the Army, he had not mentioned these peculiar experiences, "I felt it might sound queer to the doctor," he said. "And, you see, I had no

way to explain how it happens." He was unhappy in the Army and the voices troubled him so much that he finally mentioned them to the medical officer. This led to his discharge from the service. During my observation of the patient these voices continued. It was impossible to make him see that they might be a subjective manifestation. He had given up playing volleyball. "Because," he said, "when the ball comes my way they yell at me, 'That dirty c—— s—— can't hit it.' " The hallucinations so distracted him that he found the game unpleasant.

This man had, during all these fifteen years, lived quietly with an older unmarried sister and an aunt. His social contacts were sparse and superficial; but never in all this long period had his conduct been actively injudicious or made positive difficulties for himself or for others. He had worked regularly and is still working regularly and his employers find no fault with how he does his job. He has been peaceful, has respected the rights of others, and has lived without causing any particular friction or becoming a problem to anyone.

Despite this man's well demonstrated ability to adjust himself inconspicuously in his community, it is doubtful if any group of psychiatrists would fail to pronounce him psychotic. The writer agrees that he shows convincing evidence of a serious mental disorder, probably best classified as paranoid schizophrenia, and that this disorder is properly regarded as a psychosis. It is here maintained, however, that this patient, despite his hallucinations and his schizophrenia, is much less incompetent, much less in need of supervision, than nearly all the severe psychopaths we pronounce "sane".

Let us consider one of these briefly, mentioning necessarily only a few typical features of his career, since it is, perhaps, impossible to give an adequate and detailed portrayal of such a case in less than a volume. He is a splendid physical specimen now twenty-three years old, pleasing and direct in manner, the sort of man most people would be inclined at once to trust and respect. There is nothing to suggest inadequacy, pretension or insecurity in the impression he makes. He seems modest but self-reliant and able. He is not shifty or discern-

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ibly evasive, and his gaze is what anyone would call candid. His general conversation suggests the superior intelligence which is confirmed by scientific tests. There is nothing about him that seems queer as one interviews him. His parents are successful and respected members of the community. His family history shows nothing that would suggest "bad heredity" or "neuropathic taint".

This young man realizes that the examiner knows many facts about him: that during later childhood scarcely a month passed without his stealing some object for which he had no particular use, despite the fact that his father gave him an ample allowance; that he was chronically truant from school, apparently for no better purpose than to hang aimlessly around street corners or wander desultorily on the fringes of town, occasionally killing a Negro's chickens or setting fire to a rural privy; that for years he had lied without compunction but with utter equanimity and often with convincing results. What he realizes the examiner already knows he admits with the air of a man who means to make a clean breast of everything. He is firm, however, in denying whatever he thinks has not already been disclosed, and his denials are almost indescribably convincing.

His lies, like his minor but annoying acts of mischief, seem to serve little conscious purpose or to give him special pleasure. Recently he has boasted of piloting airplanes to Cuba, of living in high style with a debutante in a nearby city and, after one occasion when he was serving time in a distant jail, of having seen action in Naval battles. He once tried to pass himself off as an agent of the F. B. I. and, using this ruse, embarrassed seriously a respectable woman of superficially mannish appearance by inquiring into her sex life and insisting that the Government had sent him to gather evidence of perverse practices. Lies often brought trouble to him and he seemed to have little genuine playfulness or real humor that might have been gratified by his self-damaging pranks. He also lied at various times about having contracted venereal disease and of unenviable imaginary prison experiences.

He lives with his parents who seem devoted to him. For weeks at a time he wanders off from home with no warning to either of them and is apparently quite callous to any anxiety they may suffer. He says, however, with tones that seem to carry deep sincerity, that he loves his mother and that to cause her the slightest pain distresses him. Usually his whereabouts are made known by his appealing for his father to come and secure his release from a jail.

Reliable information indicates that this man has been arrested already between fifty and sixty times and that he would have been arrested several hundred times had it not been for his father's repeated intervention, at great trouble and expense, to shield him from the consequences of his acts. He has forged his father's name to checks scores of times. He has regularly stolen goods from stores in which he has been fitfully employed. On one occasion, with little or no provocation, he struck another man on the head with a piece of iron. Again, after a childish brawl in a juke joint, he was involved in a shooting episode in which another man was injured. He began to steal automobiles while still in his 'teens. Though his father, suspecting an understandable desire to possess an automobile might prompt these acts, bought him one, he continued to steal others. He admitted parking his own car and getting out to drive off in another, which, however, he abandoned without realizing any pecuniary gain. After being imprisoned and then put on probation for the theft of a car which he drove across the state line, he soon stole another and drove it to the same place. His ability to foresee the consequences was excellent. On another occasion, while on parole from a penal institution where he had been sent for stealing another automobile, he repeated this offense, apparently without need, plan or any particularly strong conscious impulse.

On being pardoned recently while serving a prison sentence, long before the term expired, he went to work in a war construction plant where his employers reported him remarkably irresponsible. He would quit his job at any time he chose. When taken to task for such behavior he sometimes had ingeni-

ous and entirely false excuses which he offered with convincing effect. At other times, he merely stated that he did not feel like working. This employment was terminated by his theft of a valuable piece of machinery for which he had no use. In jail, he bemoaned his fate and begged for another chance. He spoke so well, and so adequately described the need for changing his ways, that his father paid a considerable sum and, through influential friends, got him released. Two weeks later, he stole another automobile.

This man's misconduct regularly put him into uncomfortable situations. It seemed never to have any motivation that could be considered, in the ordinary sense, sane motivation. As a boy of thirteen he often discomfited his parents and outraged clerks by stealthily passing intestinal gas while new clothes were being tried on him in stores. This practice was also a popular one with him when he sat with his parents in their pew during church services, particularly in the winter when olfactory stimuli were at their best. He always showed good control of such functions under different circumstances. A significant point is the lack of anything in his attitude that resembles the contagious sense of good fun which seems to prompt the ordinary boy, however ill-timed or regrettable his pranks may be.

This young man's behavior, unlike that of a mere criminal, showed little direction toward any rewards or goals. Many of his destructive, antisocial or annoying acts seemed as though designed to bring penalties and humiliations upon himself. Despite his excellent reasoning powers, he has notably failed to take precautions against being found out and brought to punishment. Nor has the punishment seemed to influence him. His misbehavior is often so uninviting that one can scarcely ascribe it to mere weakness in yielding to temptations. Several years ago he casually married a woman who had often before been shared during a single night in quick succession for a moderate fee by himself and several acquaintances and whom they all referred to as a "dirty whore". He promptly left her

but showed no evidence of chagrin or regret nor any sense of responsibility towards her.

Some years ago he lied with easy nonchalance to exonerate himself from the charge of defecating into the many-stringed complexities of a piano that stood in the auditorium of the high school which he attended. His protests were so free of anything that might arouse suspicion that few could bring themselves to doubt his sincerity until proof was final. He showed no apparent emotional response either to having the deed established as his own or to being so flagrantly caught in his lies. The demonstrated emptiness of his "word of honor" on which he had leaned so impressively seemed now to him a thing to be treated as casually as the refutation of *Little Red Riding Hood*, *Jack and the Beanstalk* or other fables one has been telling a child, should the child set out to make them. Yet within a week he was again giving his "word as a gentleman" about other matters and with every evidence that he expected this to be accepted as final.

These random snatches fail to do justice to our patient's story. It must be remembered that he sometimes goes for a month or more without getting into serious trouble. During these intervals, while he is applying himself, his work is excellent and he makes a favorable impression on everyone. Never in a direct psychiatric examination has he shown anything regarded as a sign of mental disorder. If his history as furnished by others were not available, no psychiatrist during an interview could discover anything in evidence which would indicate that he is not a normal and highly competent person. His expressions of remorse, his promises to reform, his discussions of past mistakes are not obviously false or easy to see through, like those of a child or a mental defective. The examiner believes that, in an important sense, they are not false, at least not voluntarily false with all the assumptions this would ordinarily imply. The patient himself has no way of realizing their falsity, since *false* and *true* lack for him the distinction these words convey to others.

This patient is regularly declared by psychiatrists as being

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without psychosis, and in the courts is judged sane and competent when the question of committing him to a psychiatric institution arises. Nevertheless, juries seldom find it possible to be fully convinced by the rather abstract opinion of experts when, as Li'l Abner of the comics says, *any fool can plainly see* that such a man is seriously disordered. Therefore, as with so many similar cases, the courts refuse or are unable to punish him or to restrain him as they would an ordinary offender. These laymen, sensing that such a lack of sane conduct must indicate mental disability, no matter what our classifications maintain, allow their common sense to sway them in most instances when the psychopath is being tried for his misdeeds. They can not, however, go so far as to commit him to a mental institution against the advice of the psychiatrists. Sometimes physicians admit that he is incompetent by the subterfuge of saying that he is a case of *Psychopathic Personality with Psychosis*. There is, however, no additional psychosis, aside from what he regularly shows in his behavior, and public psychiatric institutions promptly dismiss him as sane and competent, often reporting his status as (1) No nervous or mental disease, and (2) Psychopathic Personality.

The practical results achieved, aside from the theoretical considerations, are for the psychopath to be released by the courts because of his abnormality, and to be refused or discharged by State Hospitals because of his "sanity". He remains, therefore, without treatment or supervision of any kind, and to an amazing degree immune to the ordinary restraints of law.

It is perhaps not too far afield from the practical to suggest a reason why psychiatry has been so reluctant to accept the disorder of the psychopath as a true and serious illness. This, I believe is because it is a deeply central disorder with little if any of the peripheral manifestations seen in most psychoses and considered as necessary medical evidence to establish the presence of serious mental derangement. As in speech and other specific part-functions of the organism, so, too, in

the totality of functioning, in personality reactions or human behavior, disorder or disease may occur at or near the surface or far within. ²

A man whose tongue has been mutilated has not only a defect in speech that is demonstrable when he tries to talk but also a cause for the defect that is obvious if he merely opens his mouth. A lesion of the hypoglossal nerve interferes also, but less externally, with the function of speech and leads to paralysis and in time to atrophy of the tongue. Damage to the motor cortex or in the corticobulbar tracts may also produce dysarthria with less obvious and less complete loss of movement in the tongue and without any change in the structure of the tongue itself. Destruction of neural tissue elsewhere, in various parts of what is sometimes called the quadrilateral space of Marie, is likely to leave the tongue and other muscular mechanisms not only undamaged structurally but quite free of weakness and capable of all normal functions. Yet the ability to speak intelligibly may be more seriously curtailed than in the patient whose tongue has been mutilated. Now, too, as we place our lesion more centrally, we find that our subject not only has difficulty in expressing himself but also a diminishing ability to understand what words mean. He has a much deeper and broader loss of what language contributes to functioning than the man whose tongue is destroyed. He is handicapped even in the use of words silently in his thinking. If we postulate a still more proximal site for our pathologic process, perhaps in the supramarginal gyrus, we find that the essential significance of words for the patient is almost entirely destroyed. The peripheral apparatus may, however, be intact both in structure and in function. The patient may be able to utter words mechanically, perhaps even fluent sentences; but it is not truly speech, only a mimicry of speech. His words and his sentences do not represent anything within and are disconnected from facts, feeling, intentions and from all that the identical sounds would signify in another. He is merely going

through the motions, releasing automatisms which even for him have no meaning.

In the functioning of the organism as a whole, in the living of the person as a human being in his social setting, we also find disorders that vary over a wide range from the more peripheral and obvious to the more central and recondite. The confused, disoriented victim of a toxic delirium has a psychosis that shows up maximally from the outside, one might say. Many schizophrenics are well oriented and alertly conscious and can express themselves sensibly on a number of subjects. More of the outer forms of normal behavior may survive in such cases than in those with a toxic delirium. Most cases of true paranoia one might class as much less disordered peripherally. The actual disorder may not appear at all during an examination. Such patients in their dress, their manners, and in everything one can demonstrate, show no difference from the most normal of their fellows. In reasoning power they may excel their examiners. The paranoiac may deceive not only the casual layman but often the courts and, showing so much excellent functioning on the surface, establish his sanity despite the testimony of the psychiatrists. The paranoiac may not only succeed in business but may also convince others that his delusions are valid and make many converts. Only at a very deep, a nearly central level, can his delusions be discovered, and his clever and effective outer functioning often works to make this discovery difficult.

In the psychopath one does not find even the guarded delusional substructure upon which the paranoiac correctly and logically builds his superficially rational but truly psychotic patterns of living (functioning). Only at a more complex, a more central level, at the very core of the organism, is the root of the psychopath's disorder to be sought. As the patient with semantic aphasia forms the words of speech and even produces glib sentences, so the psychopath with his semantic disorder produces the words and sentences, one might say, goes through all the outer forms or mechanisms of functioning as a sane and responsible being; but his words and sentences and all of

his productions are as empty as the "speech" of the victim of this most central aphasia.¹

When he is examined for delusions, hallucinations, or the other traditional and more superficial signs of psychosis, we find him intact. At a semantic level only can we interpret his disability. As a paranoiac deceives the layman and often passes for a sane man, so too the semantically-disordered psychopath has deceived the psychiatrist. The writer is not reluctant to grant that this disorder, viewed theoretically, is a subtle one, and that the psychopathology here suggested is debatable and scarcely to be proved in courts.

We do not, however, need to be so ambitious. One need not decide now just how and why these patients are disordered.

The point of eminent practical importance is to examine their behavior to see if they show themselves disordered, and to free ourselves from the tyranny of a verbalism that still prevents us from treating them as we do other patients who prove themselves incompetent.

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ESSENTIALS IN HELPING PEOPLE

KENNETH E. APPEL, M.D.

In all social relationships people stimulate and influence one another. The influence may be helpful, harmful, or indifferent. Social workers, psychologists, vocational counselors, court officials, the officials in jails, personnel in reform institutions, parole officers, teachers, clergymen, psychiatrists and physicians, try to influence other people constructively. This discussion is an attempt to present the essentials to be borne in mind in trying to be helpful to others. The principles are drawn from psychiatric practice, for its methods are essentially applicable whenever one person is trying to influence another constructively. Psychiatry is concerned with helping to redirect energies into more effective and satisfying channels. It deals with the more extreme difficulties in which efforts to influence are frequently resisted and blocked. The dissolution of these resistances and blocks is often effected by the means here presented.

People are helped when we do something for them in our contacts—our social relationship—with them. The best way of helping people, however, is not usually by means of the ways most commonly tried. Very little help results from giving financial aid outright, offering advice, claiming superior knowledge, using authority, coercion, bullying, manipulation, criticism, shaming or deflation, suggestion or moralizing. People are most helped by the attitudes we show when we are with them. They are helped by *what they experience* in our social relationship or contact with them.

Often the first thing people think of when a person needs help is to give financial assistance. Very often this is quite the wrong thing to do, though the person concerned may think it his greatest need. One of the problems of maturity that we all have to learn is to work and act within the limitations of

the environment and background in which we find ourselves, and within the limits of our capacities. Financial aid may postpone the facing of a problem and prevent the growth that is necessary if a given person is to make a success of life.

A woman of 48 was an only child of a well-to-do family. She had been brought up in ease and comfort. She was over-protected and had never reached any real maturity. She married, had children, and was divorced. When the money she had always depended upon was lost by poor management, she became panicky and sank into a serious nervous depression. The first thought of relatives and friends was to take up a collection and send her to a private mental hospital where she would have received excellent treatment, but where her dependency on those contributing to her care would have been encouraged. Fortunately, they decided that what she needed was not more protection and support, but something that would teach her how to use her capacities and abilities and her real intelligence, and how to make her use her warmth and attractiveness. She was therefore sent to a state hospital where she received treatment, faced limitations, and discussed the problems of life. By facing her problems, by discussing them freely, she became a mature person. She left the hospital, accepted her responsibilities, and has held a job for years. She is of much grater value to herself and others than if she had been given financial help and allowed to continue her immature life pattern of dependency.

The next thing that occurs to us when we think of influencing other people is to give advice—to give the knowledge we think necessary. We try to use our influence through suggestion, urging, exhortation or appealing to will power, or we use the intellectual way of explanation. Sometimes we use criticism which leads to shaming, or we may think coercion is the best way. Some in the field of psychiatry are apt to say: "don't be a baby, stand up and be a man, forget your troubles". In thinking of all these ways we have to consider whether they really help. If they do, is the help lasting? Do any of them make the person more mature, rugged, and effective? Do they

make him more enthusiastic? Do they inspire him or make him more cooperative? They usually do not have the effect desired. All these methods are, in a sense, forcing, and forcing by authority. If such methods are used by an employer, the employee must do as he is told, but does he do it willingly? Do these methods make him want to stick to the job and desire to give more than is required? Do they add to his morale? A person with good morale is one who will persist in the face of difficulties and who will give more than is expected of him. The chief reason that the answer to the above questions must be in the negative is because the employee is being forced, and will feel resistant and restricted. He lacks freedom, feels imposed upon, and not respected as an individual. This is applicable in other situations in life. The doctor will find that it applies to all people except those who are terribly sick and must, for a while, be dependent. If we continue to feed a person's dependence, he will only become more dependent and more sick rather than better.

Suggestion is another common way that has been tried by many good doctors to get cooperation from a patient. The purpose is, of course, to make him feel differently; but he is apt to feel that something is being put over on him. If he has pains of nervous origin, it is equivalent to telling him that his feelings are wrong and the pains should be minimized. The patient becomes filled with fear or resentment. The following is an illustration of how this works.

A doctor passed a patient in the hall and asked her how she was. She said that she had had a terrible nightmare. He told her that the nightmare could not have been so very bad—he minimized her experience. She asked later what right he had to say that it was not bad: he had not had the terrible experience and knew nothing whatever about it. She felt most resentful. A patient may feel terribly resentful when told, "You look well today" when he feels awful and knows he isn't well.

We all have the need to be respected and to feel our individuality. We must think something of ourselves even if

we are sick and in trouble. We need to be respected in the midst of failure, mistakes and illness. If that support is gone, we have very little left. All the above methods of influencing people rely on the superior power of one person who is supposed to know more and who has had more experience. Such domination implies a lack of respect for another individual and also shows a lack of understanding. These methods are very subjective and emphasize will power; and a person can certainly give very little help if his attitude is one of power and superiority. No doctor is helpful if he does not understand the motivations, urges and feelings of the patient. The physician shows a tendency to express *his ideas*, instead of letting the patient whom he is trying to help express his own ideas and feelings, which are infinitely more important. The patient is puzzled and confused and feels that the doctor is trying to project his own thought on him. In any relationship such an attitude stimulates feelings of inferiority and impotence—both negative feelings—, and negative feelings do not bring people together; they do not inspire people to do their best; they widen the gap between people and separate them.

We often reason with people when we try to help them. I think of a little girl of 4, who was brought to me because of enuresis. She had previously been trained, her control had been established and was normal. She was intelligent and apparently happy. Purely physical measures had done no good. Medication had not been effective. Disapproval, reasoning and exhortation had not helped the situation. It developed that a grandmother had died suddenly about eight weeks before the behavior difficulty had appeared; a grandfather had had a stroke and the mother had gone to the hospital to have a new baby. The child found herself separated from the people who meant most to her. She had a great deal of insecurity, which means fear, and the fear had expressed itself physiologically in the enuresis. The child was not wetting her bed "on purpose". Often if you ask a child with behavior difficulties why he does this or that he will be unable to tell you. What this child needed instead of reasoning was kindness and pa-

tience until her sense of security had been regained. With these things given, the enuresis took care of itself and disappeared.

There is another example of a high school girl who was *stealing*. She got in trouble with store detectives and a very unpleasant situation developed. There was no essential lack of money; she was earning enough to buy the things she wanted. She had had a tremendous amount of insecurity and loneliness all through her childhood. There had been illness and mental disease in the family and she, without reasoning or deliberation, turned automatically to stealing as a way of asserting herself, of obtaining a sense of adequacy, a feeling of amounting to something. She was an unusually intelligent person, knew the moral problems involved and what the consequences would be, but she did not know why she was stealing. She was allowed to discuss her problems with the doctor—her attitudes, her feelings towards life in general, what she was aiming toward. He did not moralize, criticize nor condemn, neither did he give advice nor reason with her. The stealing gradually stopped and finally disappeared entirely.

It used to be thought that one of the primary things in treating a patient was the development of insight. I have seen many cases recover from nervous or even mental disease without developing insight or adequate understanding. Reasoning is much less effective than we would like to think: it is much less powerful than strong emotion. The intellect is only one aspect of our selves: our feelings, impulses, habits and expectations are all more important in our daily living than reasoning.

Explanation is often surprisingly valueless as a method of cure. I had a patient, a very brilliant man, who was having anxiety attacks and feared that masturbation had injured his body and mind. He had read the modern psychological literature in this regard and understood the medical opinion that it is the worry and not the habit that causes the difficulty. He had guilt about it because, in his youth, he had been threatened by his father. His recognition of this did not help. Explana-

tion is too cold and intellectual. It does not inspire or comfort a patient to be told that he is too dependent on his mother, or that he is afraid because his father punished him when he was a child. It is cold comfort in worry, depression and anxiety.

There is a lot of wisdom in the popular book which gives simple rules for getting along with people. It says—do not criticize people you are trying to help, do not contradict, do not oppose, do not argue, do not tell them they are wrong. These procedures stimulate resistance, arouse antagonism, and create further obstacles.

One large corporation has worked out a way to obtain good work from its employees. Men are stationed at certain places in the various plants as listening posts. They do not give advice but are there to listen to people who have something on their minds and want to talk—to express feelings and dissatisfactions and to get things off their chests. As a result there was a reduction in industrial accidents and in time off for sickness. There was less disaffection, management-employee relationships were improved, and production increased.

In the big bomber commands in the recent war, each group had a flight surgeon. The morale and performance of each group varied with the personality of this officer. If he was one who understood human nature and had a warm nature himself, if he allowed men to talk and get things off their minds, the morale of the whole group was good, performance was better, and there were fewer nervous breakdowns.

The heart of all of us is our feelings, emotions, impulses—not our intellect nor our ideas. It is not because of their intellects that we like our friends: it is deeper than that. Attitudes, behavior, smiles, tones of voice, manner, make people appeal to one another, bring them together. So it is the attitude of the doctor, his behavior, the way he treats a person, which are the important tools in psychiatry. These things are much more important than what he says, or the information and knowledge he displays. If a human being is warm, con-

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siderate, accepting of differences, tolerant, reasonably tactful and understanding, and if he expresses evidence of trying to aid an individual, he can say unwise things or even untrue things and still be a help to patients. He is giving them security and freedom to express themselves and be themselves (at least in verbal and emotional expression to the doctor).

Many of the failures in psychotherapy can be accounted for by the attitude of the doctor who says, in effect, "I have the explanation of your condition, I know what you ought to do, so you take my ideas and adopt them and you will get well." This is psychologically unsound; it is a form of domination and imposition, and the patient feels resentful. What we must do is help the other person develop his own ideas and his own attitudes within his own background and from his own experience, not ask him to take our ideas. We come from different backgrounds and have different needs. If this is the case, how is it possible for *us* to develop ideas that are going to be satisfying and effective for another person?

The physician will find that his warm, considerate, tolerant attitude, his understanding and his willingness to help, are more effective in therapy and more important than his knowledge of psychiatry and psychology. There are people who can help others in serious conditions without technical knowledge, because intuitively they feel what other people need and they minister to those needs. I have seen psychiatrists whose knowledge was limited, who have borne in mind and practiced these principles, who have been patient and understanding and who were considerate of the patient's ideas, his suffering and his feelings. To such men the patients respond constructively and become well.

In a relationship which is only on a serious, intellectual plane the patient will be hesitant and feel afraid to express himself on things about which he feels anxious and ashamed or depressed. In order to achieve a dynamic relationship, several things are necessary. We must first bear in mind that experience and personality are broader than intellect, and greater than reasoning and explanation. We must remember

that the *feelings* of the patient in contact with us are more important than what we *think* of him: his feelings are more important than our thoughts. In addition, all people have *needs*. If we bear in mind a few fundamental strivings which are part of all human nature and try to administer to them and facilitate them, we will be helpful. I have heard people say, "That doctor can't help me, he isn't interested in the way I feel. He only wants to express his own ideas and feelings".

We must administer to the need the other person has for security and support—which does not mean indulgence. It is always possible to express hope and confidence in someone without guaranteeing that he is going to become completely well or get over his difficulty. Being too positive about this is not as helpful nor as challenging as saying, "I think there are forces in you that will become mobilized and get you well (or) over your difficulty". This is reassurance rather than a guarantee, and such an attitude will stimulate initiative, constructive activity, and cooperation.

I recall a child in high school who was stealing. The principal and his teacher lectured him and punished him. This merely stimulated his ingenuity. Finally another teacher became interested in him, and was friendly; they did things together and the boy felt free to express his feelings and discuss his problems. The stealing ceased without any reasoning, exhortation, or moralizing on the part of the teacher.

Even a person low in moral judgment and behavior or one with a child-like dependency needs respect. If we leave him without respect he will have nothing to go on. But if we accept him without criticism no matter how irritated we may feel, he will have something to use as a springboard from which he may go forward and develop.

People also have a need for responsiveness and the knowledge that someone is *trying* to understand. We can give this assurance by being a good listener, and a good observer, and being rather passive verbally. We will ask an occasional penetrating question which will help the patient to express, "get over", or get across the feelings which may be interfering with

his life. Asking questions is important if we do not make them too frequent or too complicated. It is much better than telling the patient things in that it shows our confidence in his ability to think and size up situations. It gives him freedom to express his feelings, and the free and frank expression of feeling to another human being may release and dissipate the malignant tensions and obstructions which are the chief causes of difficulties. Free expression of feelings and emotions to another human being who is friendly, tolerant, and understanding dissipates difficulties in a surprising number of cases. After intense and malignant emotion and tension are discharged, one is often able to take the initiative, to see correlations and to start to take responsibility. One gains confidence and a feeling of sharing and togetherness. Then one is often free and able to take up life again on a new and constructive plane where reason, ambition and conventional cooperation can function once more, untrammelled by excessive and disruptive feelings and tensions.

Obviously, it is impossible for us to give anyone complete understanding and complete security; but let us give what we can. Let us give, also, respect, consideration, recognition and appreciation, acceptance and tolerance. When we are trying to help another, let us give him interest, responsiveness, understanding and a sense of sharing. If we can give these things—whether in a few minutes talking, in a shake of the hand, the tone of voice or in a conference—security will develop and it will help dissipate disabling emotions. And if he can get rid of these emotions, his capacities and skills, his reason and intellect, and his moral forces will be able to reassert themselves.

RAPPORT IN THE PENITENTIARY

GEORGE J. TRAIN, M.D.

Introduction: Psychiatrists will discover that the development of rapport in penological institutions is no simple matter. Fresh from private practice or the mental hospital, they are confronted with a situation in which they are transformed from pillars of society and objects of veneration and awe to bitterly hated symbols of authority and punishment. The argot of the prisoner (bug man, bug doctor, creep, ghost, etc.) clearly reflects the belief that the function of segregating the psychopathic personality and the psychotic is ever present in all the relationships of psychiatrists with inmates. All the more, then, must we remember Freud's⁵ admonition not to expect the patient to reveal his secrets easily; for certainly this attitude on the part of the inmate obviates the very sincerity and sacrifice necessary to promote therapy.

The inmate, more than the patient in private practice or even the recoverable subject in the mental hospital, clings tenaciously to secondary gains of illness. Moreover, an unsympathetic inmate population and some uninformed officials promptly stigmatize him as "insane" once he consults the psychiatrist. This is one of the most prominent reasons for estrangement between psychiatrist and inmate, and it suggests the need for a thorough education program. Then, too, under ordinary circumstances an inmate refuses to permit the stirrings of the repressed. It is no surprise, then, that he avoids the psychiatrist.

The task of developing rapport with the penitentiary inmate is, therefore, most arduous. The psychiatrist must break through a thick layer of conscious fear and suspicion before he can even hope to obtain intimate utterances from the in-

mate. To do so, in this situation, the doctor must be superlatively sincere, kind, and sympathetic. When the inmate is convinced of the doctor's sincerity and interest he will seek help and confidences may be expected from him.

This paper is designed to present some problems of inmate resistance to rapport and to suggest means to overcome such resistance.

The psychiatrist's attitude: Attitude is the vehicle for the application of ideas. Attitude attracts or repels people. Attitude is indispensable for rapport. To begin with, therefore, the psychiatrist must exhibit an objective-sympathetic attitude towards the inmate, with stronger emphasis on the sympathetic component. The development of this attitude is predicated on a familiarity with the psychodynamics of inmate behavior. Furthermore, the psychiatrist must become intimately acquainted with several features of punishment which merit special consideration; he must recognize certain responsibilities inherent in his position; and finally he must yield to self-analysis. In a paper⁹ on the psychodynamics of the inmate, the writer described the penitentiary as privative-punitive-rehabilitative. Here it was emphasized that even modern penology tends to deprive the inmate of love and consideration which, reinforced by deprivation in the past, results in intense affect-hunger. Moreover, the inmate has been schooled by bitter experience to fear and suspect authority. The psychiatrist is no exception and to the inmate body he is a formidable opponent. He can declare one "insane" and arrange a transfer to a mental institution which may mean the loss of good time. His impressions, the inmate believes, may be discrediting and so, upset his parole possibilities. Even if he recognizes the need for psychotherapy, he strains every fiber not to yield lest he be ridiculed and pointed at as "insane" by an unsympathetic inmate body. For these and many other reasons of similar nature, the psychiatrist is received coolly and seldom consulted by the inmate. and when the inmate is finally driven to such a course it is with

unrelaxing caution. Obviously the psychiatrist must dissipate this troublesome cloud of fear or he is certain to lose unmistakably rich possibilities for study which the penitentiary offers.

Other adverse inmate reactions based upon personality and situational conflicts generate many disappointments which the psychiatrist must weather. The inmate will attempt to deceive him with all categories of medical complaints, or lie deliberately about problems in population in order to obtain privileges which will remove him from the threatening reality of prison routine. The psychopathic personality will relapse while under therapy and demonstrate his inability to displace a healthy attitude to others.

Joe, for example, is a poorly organized, unstable psychopath who had committed numerous conduct violations. While under superficial suggestive therapy he adjusted marginally and was helpful in organizing a "Human Relations" class designed to study the response of the psychopath to group psychotherapy. Interestingly enough, during this period of treatment which lasted three months, he avoided disciplinary problems by "somatizing" his complaints. He managed to visit the hospital practically every day, usually for physiotherapy. As soon as such prescription was officially cancelled and Joe was cautioned about unnecessary clinic attendance, his usual surly behavior pattern reappeared and he resumed his visits to isolation.

Even Dick, a chronic complainer with whom some therapy was attempted, couldn't contain himself when refused quarters. He called the writer a ten-cent psychiatrist, adding, "You wouldn't be here if you could develop a private practice." He has since apologized and is adjusting surprisingly well.

The explosive characteristics of some inmates challenge the personal integrity of the psychiatrist.

Tom is illustrative. He suffered a severe dermatophytosis and upon admission to the hospital was isolated. He protested the incompetence of institutional physicians and insisted upon consultation with one from his home. He refused to cooperate and one evening was found fraternizing with other patients. Admonished by the writer that isolation

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was imperative for the safety of other patients, he became excited and abusive. He was permitted a stormy catharsis and when his tension subsided it was gently and dispassionately suggested that he consult the Neuropsychiatric Department for therapy. Other inmates, who witnessed this scene, insisted that we were positively justified in subjecting the inmate to disciplinary action. However, the following morning we were rewarded for not doing so. He came to apologize and consult with us regarding his explosive behavior. He described a chaotic rearing devoid of friendly guidance which, he insisted, resulted in emotional instability and frequent conflicts with authority. For the remainder of his stay in the penitentiary, he was cooperative and respectful towards this department.

Also disappointing was the failure of psychopathic personalities to interest themselves in a group psychotherapy program which was planned especially for a study of their behavior in a group. The class was well attended by the psychoneurotic and the well-adjusted individual, but not the psychopath. Of those few psychopaths who did attend, many retired in protest against the verbal testimonials or the talkativeness of some of their fellow inmates.

These are but a few examples of a multiplicity of inmate reactions which are disturbing to the psychiatrist. They must necessarily be thoughtfully reviewed by him should he wish to develop rapport. He should observe that cooperation with authority brings little immediate reward to the inmate and, further, that some are apprehensive regarding the significance of a satisfactory adjustment to the penitentiary. One superior inmate, given to hypochondriasis, commented uniquely in this connection: "If I were to adjust to the institution it would be conclusive evidence that I am deteriorating and becoming submissive and would be unable to resume my life in the free, competitive world." Correction of this attitude is obviously possible only with rapport. Actually, good time earnings are not appreciated by the immature and unstable inmate. Adjustment to institutional demands necessarily imposes the reality of the penitentiary and many just cannot bear up under such a weight of restrictions and social artificiality. In passing,

it is worth mentioning for the doctor's own professional security in consideration of the many varied problems and individuals, that rapport cannot be established with all inmates, particularly with the psychopathic personality. He is notoriously resistive.

The subject of punishment is amply discussed in most recent texts on penology and further elaboration would be superfluous. Certain features, however, merit special attention. Punishment is currently the province of the custodial department and it will continue to be practiced by them until psychiatrists can provide a concrete program of therapy. Actually, psychiatry is as Alexander and Healy state, "... still concerned with provoking thought rather than the formulation of a specific program."¹ Certainly the effectiveness of punishment in curbing intractable recidivistic criminals is open to serious question. It is frequently observed that punishment when imposed by an unloved person arouses hate in the inmate rather than a feeling of guilt and the need for self-appraisal and correction. Many inmates rationalize to the effect that by abandoning unsocial habits in the penitentiary they would bring credit upon officials whom they despise. Why, then, should they respond to punishment? In general, for practical purposes, even the belief that unconscious punishment is a need may be discounted, particularly in consideration of the unmanageable inmate. Probably his ego finds it necessary utterly to reject this need for punishment for fear that with its recognition other associated deep-seated and more terrorizing conflicts, which he strives to repress, will be released. Or is it that the type of punishment he experiences is rejected by the unconscious as unsatisfactory? Consequently, the impressions of punishment are at most superficial and the extraordinary inmate, as a rule, rationalizes his anti-social behavior by casuistic projection upon his punisher. But, certainly, there need be no occasion for the doctor personally to prescribe punishment once rapport is established, for he possesses other means, perhaps equally distressing yet much more impressive. Rejection, for one, is a prepotent instrument; it is poignant.

Should the psychiatrist recommend punishment he unquestionably alienates the inmate body. Emotional whipping is not far removed from physical whipping and interesting in this connection is Warden Merserve's opinion quoted by Ettinger: "Men who have been whipped are never as good prisoners as before."⁴ Finally, regardless of the attractive environment and the satisfaction of physical needs which the modern prison provides, the psychiatrist must remember that incarceration is intrinsically punitive.

The very responsibilities of the psychiatrist are added reasons for the development of an attitude which will attract the inmate. Familiarity with the formidable proportions of crime and its appalling waste is stimulating and emphasizes a professional duty to society to investigate this huge problem for purposes of prevention. The task of diagnosis in the penitentiary, prompt segregation of the psychotic, education of the custodial officer to recognize the dangerous criminal as well as to understand and interpret human behavior, are all serious responsibilities. Therapy, of course, is a major problem and every available instrument and technique should be utilized in the treatment of the inmate.

Our attitude requires an additional recognition—that of self-analysis. However limited and difficult this practice is, the physician should attempt to understand his own personal needs and drives and, if necessary, attempt modification at all odds. Is he the narcissistic, aggressive person who thrives on power over men? Then the penitentiary situation provides fertile soil. Is he indifferent to the plight of the inmates, deliberately restraining his initiative because of a fear-dominated personality which cannot brook criticism from superiors? How productive can he be? By what objective standards does he measure administrative approbation? Is he especially intolerant of the criminal? He will do well to remember that intolerance of other's misdeeds is a sign of struggle in repressing his own unconscious anti-social wishes. Finally, is he inclined to identify himself with the victims of a crime and regard the

criminal with contemptuous fear? His assignment is then wasted.

Fully aware of inmate psychodynamics, certain features of punishment, his responsibilities as a physician, and acquainted with his own personality deficiencies, the psychiatrist is then capable of evincing an attitude of objective-sympathy flavored with firmness. Crime becomes a symptom complex under these circumstances, and he will conclude with Cleckley³, for example, that the psychopathic personality is ill and betrays unconscious motivation even as does the schizophrenic. His major interest becomes the secret behind criminal behavior, and his problem is how best to reach the inmate for intimate utterances which pave the way to unconscious treasures.

The approach: In developing rapport, the psychiatrist's immediate objective should be to attract inmate attention by gratifying his intense affect-hunger. Once the inmate's attention is obtained, curiosity and interest in our services will be aroused and finally faith and trust will promote sincere wishes for therapy. In this connection, the principle of identification is appreciably effective. In satisfying affect-hunger and thereby becoming an object of veneration and love, the psychiatrist as well as other officials with whom the inmate associates could provide examples of well-integrated behavior after which the inmate can model himself in his relations with others. For practical purposes, general rapport may be recognized when the inmate expresses the feeling that he is not regarded "as a dog". It is certainly evident when the inmate becomes disconsolate at the mere suggestion that he has by some chance utterance or behavior reflected on the physician's integrity, which is summed up in the expression: "put the doctor in the middle".

The psychiatrist's office must provide an atmosphere of warmth, privacy, and secrecy to attract confidence. Once the door is closed this room must create the feeling that the penitentiary has been left behind. A copy of the "Hippocratic Oath" should be prominently displayed and referred to freely

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in order to assure the inmate of a vow to secrecy. Only unusual intrusions are permissible; for the subject must be given undivided attention.

The doctor's inmate clerk offers a promotional opportunity for overtures to the inmates, and through friendly comradeship with him the soil for wider rapport can be established. His first name should be used freely, for it recalls loved ones, and he is prone to transfer affection to the physician. He should be greeted warmly and his advice sought, with cautious application, upon administrative and inmate problems. He is informed and can educate the doctor about the needs of inmates. Upon informal request he can assemble small groups of a half dozen inmates for a "bull session" regarding personal and general penitentiary problems. During early sessions, the doctor's sincerity and trustworthiness will be tested and, when the inmate learns that he may speak fearlessly and that his utterances will remain secret, he will become an invaluable source of information. Many inmates evince an irresistible urge to speak and, since the freedom of expression is generally forbidden elsewhere in the penitentiary, given the opportunity, their vocalizations assume cathartic proportions. The doctor should listen. It is an illuminating experience for him and fulfills a lack in the lives of the inmates. As these sessions become more frequent, attendance of itself indicates a modicum of rapport. The physician can then intuitively and skillfully direct discussions to the criminal act. In this connection, it is important to remember that the inmate is plagued by his offense because of the costly effort at repression of guilt in order to cloak himself with innocence. Actually, until rapport is well established, even casual reference to the offense estranges the inmate. With Lichtenstein⁶ we agree that the offense is not the doctor's concern; certainly not in his early relationships with the inmate. In our experience it was not long before other inmates requested the privilege of attending these sessions. Through these meetings we were able to learn much about inmate behavior, grievances, and especially how difficult and perplexing is the problem of crime. We also

observed that even in these small inmate groups individual differences and the absence of mutual sympathy appeared in stark relief.

Helpful indeed in developing rapport is frequent attendance by the psychiatrist upon institutional functions. These include the church, indoor and outdoor stockade, the motion pictures, work details, as well as the mess hall. If practicable he should visit living quarters. Inmates express their gratitude for his presence and several have declared that the blot of "untouchable" is rendered less cutting.

The psychiatrist should practice general medicine in the penitentiary with an eye to psychosomatics. This provides another significant avenue to rapport with the general inmate population. It is here that the psychiatrist can render a measurable service which is divorced from the stigma of mental disease. Physical examinations, liberal prescription of drugs, including the placebo and physiotherapy satisfy an infantile wish for interest and attention. During the early drama of seeking rapport, these services should be prescribed freely. Moreover, (and we have made it a practice to do so) patients should be seen as frequently and even as irregularly as they wish until they become suggestible and can be taught that the psychiatrist is overburdened. It was formerly common for an inmate to stomp off in a huff when informed that the doctor was too busy for consultation; currently, it is unusual. Fundamentally, it is not what is said to the inmate, but the attitude and tone with which it is said that alienates or magnetizes him.

A note of caution! The physician will naturally be abused when he displays kindness. So hungry is the inmate for affection that he devours it and insists upon more. He will seek quarters and convalescence, a change in detail or sleeping quarters in order to obtain a simpler reality and escape the burdensome monotony of institutional rules and regulations. These requests should be granted with discreet liberalism. The more practiced senior physician will inform the novitiate when he is out of bounds in this regard.

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Other general attitudinal rules, no less important, must be heeded. Prejudices of any sort must be strongly repressed if they appear in the psychiatrist's personality. Favoritism or rejection, as interpreted by the inmate, are risky and invariably invite criticism from the inmate in symbolic behavior. For example, while walking through the corridor the doctor must either greet or ignore all inmates, or he will soon note unmistakable evidence of recrimination. To illustrate:

One day George became cool to the writer, whereas formerly he had been quite friendly. When approached for an explanation regarding this attitudinal change, he announced he had been ignored by the examiner a week before when his greeting in the hallway elicited no response. He felt at the time that we had become disinterested in him. An explanation of assurance to the contrary was warmly received.

Harry and Bob were both on the Neuropsychiatric Service receiving narcoanalytic therapy. If Harry were treated first, Bob would pout and sulk, and *vice versa*. When Harry required considerable, persistent attention because he had reached a critical stage of analysis, Bob paced the floor in silent desperation. Both inmates are psychopathic personalities and their infantile need for love is so profound that any sign of rejection arouses distress. Unless we devoted ourselves fully to Bob, he employed all the attention-seeking devices known to him. (This reaction is, incidentally, useful in prognostic determinations.)

In framing our attitude towards the inmate, much can be borrowed from the mythical criminal code to which he must usually subscribe or suffer reprisals. Prominent among the code rules, as listed by an inmate, are the following: "Don't rat; don't lie; be a right guy; be tough, but don't be a bully; treat everyone alike; don't be G. I.; help a guy out; keep your word; don't gossip; be generous." Under no circumstances should the physician make unfulfillable promises. In general, straight-forwardness and honesty are well received by the inmate.

The fact that Charles was informed we could not recommend him for Army induction because of his emotional instability did not embitter him. Before he left the Neuropsych-

chiatric Service we made certain that he understood *why* we could not recommend release to the Army, without compromising our professional standards.

It is the psychiatrist who must make overtures to the patient, for reasons noted above, and a more active type of therapy is essential. The inmate is different from the patient in private practice who, as a rule, reaches for the doctor and is, incidentally, much more respectful. Furthermore, the private patient can escape us when a threatening or an embarrassing situation arises. This is not so with the inmate; one avenue of escape is closed to him, and he is abysmally anxious about the incorporation of intimacies in the record. The inmate requires a liberal degree of attention, honesty, and kindness, and the psychiatrist must prepare an attractive dish. The inmate's preference should be our guide. If he prefers to speak, the doctor must listen despite the likelihood of being led through a maze of non-essentials. A patient, deeply engrossed in heterosexuality on the surface but obviously driven by homosexuality, sent in a note: "I'll see you but you must be quiet and let me do the talking. I'll tell my story but don't, I beg of you, laugh in my face." Usually the subject requires and urges questioning for an indefinite period of time until he relaxes sufficiently for free association. In commenting on their behavior, the psychiatrist must be certain to caress with an asset while he stabs with a liability. Sermonizing is futile. The psychiatrist is not dealing with moral issues but with symptoms. Absolutely no orders are to be imposed upon the inmate without an explanation of the reasons for such orders.

Frank, for example, had exposed himself to disciplinary action by starching his collars in the Laundry. He is a mental dwarf and protested the punishment he received (which consisted of restrictions) with anxiety, tenseness, and a request for quarters. He was surprisingly receptive to the explanation that starch is a war essential and must be used sparingly.

Psychosomatic interpretations must be expressed cautiously and through indirection lest we antagonize our patient. "Do you think I'm crazy, Doc?" is the usual rejoinder.

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Carl demonstrates an interesting reaction in this regard. He had attended sick line 225 times in as many days with encyclopedic, vague complaints. Repeated physical and laboratory examinations were fruitless and it became clear that his illness lay in his hat. As a last resort, despite his slow cerebration, an attempt was made to bring him face to face with the reality and significance of "gold-bricking". We explained that "gold-bricking" is a disease, a protest, that it does not respond to drugs, and that he must air his problems and learn from us to view them with adult wisdom. To this was added that he must have a painful past and that he is basically good and salvageable. He became surprisingly relaxed and much less resistive. He related that he had been born out of wedlock and had been reared in a foster home for thirteen years. Upon learning the identity of his mother, he visited her and was received at the point of a gun with the warning never to return. Obviously his complaints were attention-seeking in nature. An abundant dose of attention was administered and he finally admitted the reasons for "gold-bricking". The work he was doing, he insisted, was too much for him; he had no friends and no interest in the penitentiary. Some sincerity was noted when encouragement elicited at best a promise merely to try (with emphasis on try) to adjust to his assignment while we continued treatment. But he no longer consulted us and his daily visits to the hospital continued. Subsequently, when asked why he avoided us, he remarked, "You are too wise." Actually we had attempted to lift a crutch from under him while situational impositions, or perhaps our own abruptness with an immature personality such as his, made "gold-bricking" the more satisfactory outlet.

Kindness, of course, does not mean sentimentality and the full accommodation to the inmate's wishes. It simply means rendering the impact of reality less imposing and more consistent with the inmate's capacities. The task of tapering off quarters, for example, is illustrated in the case of Jay.

"I'm nervous, Doc, and want a day off. I'll blow my top. The machinery beats my brains out. I'll kill someone." Dramatics of a threatening nature such as this are frequently exploited in an attempt to frighten the physician into yielding to their demands. Jay, we suspected, had a deeper problem and we sought after it. We presented the signed quarters slip and added that since his wishes were granted, he should

tell us his problem. This disarming gesture was very helpful (and has been in numerous instances). He informed us that X (we never insist on names of antagonists; they must be volunteered—for the inmate fears the consequences of informing) was threatening him because of an unpaid gambling debt. We were then able to explain his nervousness, the substitutional value of complaining about machinery, his fear of reprisals if he were to seek administrative help, as well as his escapist request for quarters. Furthermore, the reasons for prohibitions against gambling were easily impressed upon him. Thereafter, Jay always expressed the truth behind situational difficulties whenever he consulted with us, and it became a simpler matter to deny him quarters if unmerited.

Frequently, too, scolding, indifference, and a threatened rejection of those with whom rapport has been developed, are helpful.

Jack and Bill were much too friendly in population and gossip labeled them as homosexuals. Having failed to separate them with kindness, we decided upon, and put into effect, a therapeutic dose of criticism and rejection. Shortly after, both came to discuss some compromise, for they could not tolerate our attitude.

Once even a modicum of rapport is established the function of the psychiatrist can be explained to the inmate to eliminate his fear and to arouse interest in therapy. It is then our practice to emphasize that examination and diagnosis are essential to exclude the "insane" from population, as we do those suffering from contagion. Crime is treated as a disease in our discussion, and the need for therapy made clear. Many begin to understand the psychiatrist's therapeutic offerings as is evidenced by the surprisingly large number of requests for treatment. The intelligent inmate, realizing and concerned with the need for research in penology, is most helpful in carrying our message to other less well informed inmates. To ally this type of individual to our cause is a triumph attainable only with rapport. Our general objective, then, is to make it clear that we are in a position of authority, but that license will not be exercised indiscriminately; or, as one inmate suggested, "This guy can hang me but he won't—he's a regular guy!"

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It is well to mention three situations which impose utmost caution upon the physician. On occasion he may be tempted to treat the wealthy patient, especially those advanced in years, with preferential consideration in anticipation of a subtly or overtly promised reward in the future. The danger of special privileges has been referred to above and, however monotonous repetition may be, it must be emphasized that preferential consideration of one inmate alienates the other.

One elderly individual, Mark, of alleged fabulous wealth, was admitted to the hospital for the treatment of diabetes mellitus and generalized arteriosclerosis. He was given to self-pity and periods of depression accompanied by crying spells which would shake the frigidity of the most objective observer. Other inmates in the hospital referred to him as the "supreme gold-brick", which opinion merited consideration. His objective was, obviously, to remain hospitalized for the term of his sentence. To permit such residence when deemed medically unnecessary would be to court popular resentment and disrespect for the medical staff. After his diabetic status was controlled, psychotherapy was instituted to prepare him for population where, it was emphasized, he would find occupation and social opportunities consistent with his needs. Every conceivable approach failed and he insisted upon remaining in the hospital. When notified finally that he was to be dismissed over his objections, he protested and threatened the writer with the responsibility for "the death of an old man who is innocent". Firmness in our decision had its reward, for following dismissal from the hospital he was assigned to the Library and when seen two days later he apologized for his tantrum. He had decided to renew his interest in reading, which had been neglected prior to incarceration. Thereafter we became friendly and upon his discharge from the penitentiary he visited the hospital especially to express his gratitude for our "kindness".

On the other hand, during the writer's early career in the institution, four inmates of the less privileged class have sought a compromising favor which seriously violated penitentiary rules. All requested him to mail a letter in order to avoid the censoring officials. On no occasion was reward for this request mentioned, which on its face suggests rapport, and in no instance were they alienated from us when their wishes were

denied. We simply informed them we had not heard their requests. Indeed, they were grateful for our "faulty hearing".

Another outstanding infraction of the rules is the indiscriminate provision of the inmate with drugs, especially morphine. The barbiturates, particularly, are treasures for which the inmate would gladly pay several packs of cigarettes (the medium of exchange in the penitentiary). The reasons for caution regarding such practices are obvious and need no further elaboration.

Results: Is this approach to rapport—which harks back to Paracelsus' conclusion, "All I can give my patients is love"—helpful? While attending difficulties clear to the penologically experienced physician make it impossible to draw any definite claims, there are clinical impressions which cannot be overlooked. Through the satisfaction of affect-hunger, with boundless optimism on the part of the physician, some rapport can be developed. The major difficulty, it may be noted in passing, is that too frequently rapport fails to transfer from the doctor to others in authority.

With caution we contend that, given this approach, even the psychopathic personality, for example, reacts favorably, however superficial and short-lived the reaction may be.

Jim is an illustrative case. He is of the garden variety of psychopathic personality whose emotional instability is easily fired. He had learned that Otto, another psychopath of greater emotional sensitivity, who had slept for forty eight hours following sedation, had charged a staff physician with having prescribed an overdose of paraldehyde. Otto made this accusation while still under the effects of the drug, obviously to cloak personal responsibilities for the misdeed, since we learned later that Otto had supplemented paraldehyde with several tablets of Phenobarbital. The actual dose of this drug was not recalled. Unknown to us, Jim became perturbed, as did several other inmates in population, for this physician had developed a laudable reputation for competence and sincerity with the prison population. Jim insisted that the doctor was "put in the middle by a punk" and planned reprisals. He was already a patient on the Neuropsychiatric Ward when Otto improved sufficiently to be admitted for observation. Another inmate, also a psychopath, but more

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mature and with whom we had developed rapport, brought the tale that no less than murder would appease the hungry group. While he would not name the protagonist, he informed us that he was a patient on the Ward. Anticipating the worst, we gathered all the Neuropsychiatric patients together and asked for an explanation of the severe tension evident that morning in order not to betray our informant. Of the seven patients present, not one volunteered information. Indirect questioning was unavailing and we notified them of the reasons for our concern. We threatened to withdraw from the Human Relations Class in which they were deeply interested; we emphasized that this class would triumph or be disgraced by this situation; we repeated that they demonstrated the very traits for which society condemned them and that their behavior was conclusive evidence that they were unworthy of interest. We stressed that they were "putting me in the middle," and finally that our program of therapy would be stopped instantly and that no psychopaths would thereafter be admitted to the Ward. These utterances could only be made to a group with which we had rapport. Guilt feeling and rejection aroused them. The seven agreed to speak in unison so that no one individual would betray the other and the truth was blurted out, with Jim announcing himself as the culprit. He insisted on retribution, however, until it was explained in firm, rejective terms that he was not especially interested in the effects of the episode upon the staff doctor, but rather that he himself was hungry for excitement. We explained Otto's distress and mental illness and finally won Jim's sympathy. That afternoon he was found at Otto's bed offering him cigarettes and pleading, "The doctor's right—isn't he?—you didn't want to put the doctor in the middle—you blew your top—didn't you?" Word was sent to other members of the punitive hungry group to pull in their fangs, and Otto was spared.

Of significance is the large number of applicants for admission to the Neuropsychiatric Ward for therapy. No objection is raised against the use of hypnoanalysis and narcoanalysis despite full realization that intimate information may be so obtained. Even psychopaths have volunteered for treatment. Several inmates, following analysis, have left the Ward with the self-imposed responsibility to prove the effects of

therapy to the general population by good behavior. One inmate, who suffered a homosexual relapse, felt he had betrayed the department and it was only by the urgings of fellow prisoners that he consulted with us again. In judging results, however, we must not overlook the reward which hospitalization offers—a simpler reality.

Finally, perhaps John's note may make the objective a bit clearer, although the result must be regarded with caution.

He is a psychopath whose tender years have already been punctuated with four prison sentences. He writes to explain his reaction to therapy: "Someone has to keep beating something into your head to keep your mind off your troubles. It makes you think of him and think of what he says. It makes you think less of authority and pain and more of friend and help. It takes your mind off the other people. Maybe not all authorities are alike, but you sort of feel that you have a friend. It took my mind off the wish to fling a knife at people in the back and no one would know about it. But the attention you gave me and the talks, that was the stuff. I know the officers have their job to do. You didn't talk to me like I was a con, a dog. You made me feel confidence and faith. I can't go wrong. You've built me up and I can't let you down. I even talk with the J. W.'s (Jehovah's Witnesses committed for violation of the Selective Service Law) whom I hated. They're all people; let's all enjoy ourselves. If I can make them happy, why not? I used to wonder why you were nice to me. I hated you. Maybe you were fooling me. But you've convinced me." John adjusted marginally while here under superficial therapy—kindness. He tried to make a go of it in the face of immaturity and severe emotional instability. While no claims of success are made, certainly his brief is stimulating, inspiring, and instructive.

Summary and conclusions: Rapport, while no simple matter in the penitentiary, can be developed to a moderate degree. It is essential for penological research, diagnosis, and therapy. The strength of every variety of psychotherapy lies in combating the secondary advantages gained by a behaviour pattern of illness or criminality. Behind such behavior is a secret. Rapport is indispensable in eliciting this secret from the inmate. This is of immense value in directing the establishment of a

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program of prevention and therapy, both of which seem currently inadequate. To develop rapport the psychiatrist must evince the proper attitude and he must be thoroughly familiar with inmate psychodynamics and situational denials. In addition, he must regard crime as a symptom complex and recognize that punishment is of doubtful value. The psychiatrist bears a burden of responsibility to society, to the inmate, and to his profession. Self-analysis, with correction of those very traits which estrange the inmate population, is imperative. The technique of rapport is basically an attitude of optimistic objective-sympathy which grasps and holds the inmate so that therapy may be engrafted. Prejudice of any kind is dangerous. Limitations are many in a prison set-up, particularly with respect to the dearth of rewards, and, since affect-hunger is intense in the inmate, this is the avenue of approach to rapport.

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INTERPERSONAL RELATIONSHIPS AMONG INMATES AND PERSONNEL

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The opinions expressed in this discussion are those of the author and not of the United States Public Health Service as a whole. The topic is too controversial to permit uniformity of opinion. By interpersonal relationships is meant the manner in which people get along with one another. They do not get along with one another perfectly even under the most favorable of circumstances. In a prison or correctional institution the circumstances are far from favorable. How can one expect mutual love, respect, and admiration between the kept and his keeper, the keeper and the reformer? Nevertheless, this natural antagonism can be reduced to a minimum if the opposing groups take the trouble to understand each other's problems and objectives.

The main objective of the kept is to get out of gaol. There are a few down and out individuals who look upon prison as a substitute home or snug harbor to which they can repair when the going gets too tough. But, by and large, inmates want no part of any prison, no matter how modern it may be. Some want freedom so desperately that they will go to any lengths to effect an escape, including the murder of anyone who stands in their way. Some will not go to such extremes, preferring less forceful and indirect methods, such as digging a tunnel under the wall, sawing through bars, and the like. Still others, retaining sufficient judgment to realize that escape will make a bad situation worse, try in every possible way to get their sentences remitted or reduced. They will prepare writ after writ contesting the legality of their indictment, their trial, or their sentence. They will seek commutation of sentence on the grounds that imprisonment is detrimental to health. They will cajole influential acquaintances or public officials to intercede

for them. However, most prisoners resign themselves to the inevitable and concentrate on getting out in the shortest regular time the law allows, that is, parole or conditional release.

Next to getting out in the free world, inmates of penal and correctional institutions are interested in making their intramural life as comfortable as possible. Their basic requirements are good food, tobacco, decent living quarters, adequate clothing, an easy job, provisions for recreation and entertainment, and a minimum of interference with personal liberty. Additional requirements depend upon individual standards. Thus the alcoholic wants his whiskey, the drug addict his morphine, the gourmand his favorite viands, and the sexual invert his paramour.

The mere fact of imprisonment does not discourage inmates from satisfying illicit desires. Corrupt employees may be persuaded to smuggle whiskey, drugs, and other contraband into the institution. Visitors may do likewise. The institutional larder may be raided for extra nourishment such as steaks, pork chops, and eggs, or for the ingredients necessary to make home brew. Antifreeze solution drained from our radiators will serve as a substitute for liquor in a pinch. Stronger inmates may so intimidate weaker inmates that they will buy protection by giving up their commissary purchases. In other words, there are opportunities for an enterprising promoter, confidence man, gangster, or thief to ply his trade even in prison.

About third in the order of importance is the desire for individual recognition. No inmate likes to be just another registered number. He wants to stand out from the rest of the horde in some fashion. A certain number achieve this distinction by persistent rebellion, inviting punishment in order to set themselves up as heroes and martyrs in the eyes of their fellow inmates. Some express their individuality by altering regular issue clothing along more rakish lines, growing a beard or mustache, having a different style of haircut, and by other similar digressions from the established prison norm. Others strive for the prestige or special privileges that go with certain

jobs. But whether they do or do not choose to be different, all appreciate recognition as individuals, to forget for a moment that they are convicts forced into a common pattern of living.

Least important, as far as the inmates are concerned, is the reformatory function of penal and correctional institutions. Practically all inmates look upon a prison as a place for punishment, not as a place for reform. Only a minority appreciate the extramural benefits to be derived from education and vocational training. Most of those who participate in such a program do so for the immediate intramural benefits. For example, it helps to pass the time; it is better to learn carpentry than to use a pick and shovel; it is more comfortable to go to school than to engage in physical labor.

One reason for his lack of insight is that in order to be reformed the individual must concede that he needs reforming. Not many inmates will make such an admission. Being human, they will almost invariably project the blame for their shortcomings upon their environment. It may be bad companions, a poverty-stricken home, intoxication, provocation, police prosecution, a "bum rap," or the fault of the victims themselves. If people did not have a little larceny in them, confidence men would starve to death. If folks are so careless as to park their cars with motors running, can you blame a fellow for borrowing such a car when he has to go some place in a hurry?

Another obstructive factor is the rigid code of the inmates which promotes their own solidarity by forbidding any crossing of the line or identification with the employees. Any inmate who violates the code is branded as a stool-pigeon to whom very unpleasant things happen, not infrequently death. Thus it is difficult to establish the cordial relationships between inmate and employee which are so essential in providing a suitable atmosphere for reformation.

The employees of penal and correctional institutions are roughly divided into two groups—the custodial and the non-custodial. The custodial group are the keepers whose primary

duty is to prevent the escape of their charges. Everything else is of secondary importance. The easiest way to prevent escape would be to lock prisoners up in individual cells and never let them out until their sentences expire. Even their food could be passed through a door in the window so that it would not have to be opened except in an emergency, and then only in the presence of two or more custodial officers.

However, long before the advent of correctional enthusiasts upon the prison scene, custodians realized the impracticality of keeping a man idle in a cell. The wasted man-power could be used to good advantage in maintaining the institution. Likewise, it is simpler to feed a group of prisoners in a central dining room than it is to feed them in their individual cells. However, such changes when put into effect entail greater freedom for the inmates and consequent increased opportunities for escape. Thus, each relaxation in custody has made it more difficult for the custodial officer to perform his duties. It is only natural that he should resist further complications.

Next to preventing the escape of a prisoner, keepers are interested in operating a smooth running institution, reducing fights, riots, homosexual affairs, and other sources of friction to a minimum. This is commonly spoken of as maintaining discipline. Through trial-and-error various restrictions, procedures, and rules have been established governing the conduct of prisoners. All would be simple if the prisoners would comply. Unfortunately, prisoners are people, and people do not like regimentation or the monotony of a peaceful existence. Even a model inmate will sometimes violate a rule just as the best of citizens will occasionally violate a traffic regulation or local ordinance. For this reason, discipline must be intimately bound up with reward and punishment, reward for good behavior and punishment for bad.

There are a number of rewards for good behavior in prison, for example, granting of special privileges such as trustyship, assignment to desirable jobs, recommendation for parole, and the like. Similarly, there are a number of punishments which can be applied, such as revocation of privileges, segre-

gation, loss of good time, or prosecution if the offense is serious enough. Most custodial officers agree that the punishment should fit the gravity of the offense, and not the personality of the offender. Each custodial officer firmly believes that his word should be accepted in preference to that of an inmate. Likewise, each custodial officer expects some action to be taken when he reports an inmate for adverse behavior. If such support is not forthcoming, discipline is bound to suffer. All custodians agree that unruly prisoners must be punished. An unregenerate few would like to see the return of whipping, beating, and other outlawed forms of punishment to keep recalcitrant convicts in line. Even if public opinion did permit such measures, it would be inadvisable because submission through fear engenders hate, and hate usually culminates in mutiny and rebellion. The vast majority of custodial officers are not vicious or cruel. Nevertheless, constant exasperation has convinced them that there is a certain type of inmate who can not be controlled unless he is made physically uncomfortable. This is usually accomplished by placing the culprit in a darkened, unfurnished room with only a board to sleep on and a diet of bread and water. Inmates refer to it as being put in the "hole". Officials call it isolation or segregation. Some form of segregation is recognized as essential by all penal and correctional workers. Society segregates the antisocial elements by imprisonment. Therefore, it is logical that rebellious inmates should be segregated from the rest of the institutional population. The difference of opinion rests upon whether the segregation should be comfortable or uncomfortable from a physical standpoint.

Custodial officers are realists. They agree with the inmates that imprisonment is punishment. Who would choose to go to prison for an education or vocational training? They are puzzled by the modern aversion to anything that smacks of punishment. Is it possible to eradicate evil by simply denying its existence? Can the incidence of crime be reduced without punishing the perpetrator? The concept of punishment for non-conformists is firmly rooted in the human race.

The Old Testament is replete with examples of what happened to poor mortals who incurred the wrath of God. Even in the Hereafter there is a punitive hell provided for the wicked.

It follows that purely custodially minded employees are not in sympathy with making prison life too comfortable. The coddling of prisoners nullifies the deterrent effect of imprisonment upon crime. Moreover, it seems like a waste of public funds to provide benefits for unappreciative criminals when there are so many much more deserving honest citizens who are denied such benefits. Then too, how do we know that education, vocational training and the like will make an inmate a better citizen? It may do the very opposite, may make him a better and more successful criminal. These extra-curricular activities also interfere with the operation of the institution by encouraging inmates to shirk work, by requiring additional officers to supervise the participants in the program, and by giving the excluded inmates something else to grouse about.

Custodial officers, too, have a code. It forbids any fraternization with inmates because such a relationship too frequently leads the officer into the kind of trouble that will cost him his job or cause him to join the ranks of the inmates himself. The experienced custodial officer soon learns that no inmate can be trusted explicitly. The codes of both inmates and custodial officers, therefore, tend to build up an invisible wall between them, a wall of mutual distrust and suspicion.

The non-custodial personnel of penal and correctional institutions are comprised of social workers, teachers, chaplains, physicians, psychiatrists, psychologists, and other professional or semi-professional people who are primarily interested in the reform of antisocial individuals. The assumption is that no individual can be so thoroughly bad as to be beyond redemption. Society and the parents are responsible in a great many instances for the criminal behavior of law breakers. Ill health, poverty, lack of education, lack of vocational training, lack of love and understanding, and other factors of a similar character contribute to the delinquency of the individual. By ap-

plying the appropriate remedial measures the maladjusted individual can be salvaged.

It follows that the non-custodial employees are reformers at heart and therefore inclined to sympathize with the inmates in their desire for freedom and in their desire to make prison less like a prison but more like an educational institution or a hospital. The professional group are generally irritated by the various custodial precautions against escape. They feel that the regimentation imposed by rules and regulations stifles initiative, self-expression, and ambition.

Yet even reformers realize the necessity for maintaining discipline, especially if they are given administrative responsibility. However, they use a different approach; instead of punishment for misbehavior they advocate treatment on the grounds that adverse behavior is a symptom of a maladjusted or diseased mind. Under the guise of treatment, measures used by the custodial force can be adopted. Thus, segregation is simply the removal of a disturbed inmate from a more complex environment to a simpler environment where he is not exposed to the stimulus of associating with other people, and where he will have less opportunity for getting into difficulties. The environment can be simplified to the point where the patient is confined to a single room and deprived of furniture in order to protect him from injuring himself or others during his disturbed state.

If the individual fails to adjust in a prison environment, the chances are that he will also fail in his extra-mural environment. Therefore, the logical thing to do is to give him more treatment by postponing his release beyond his parole date or conditional release date. In some instances it may be even necessary to prosecute an inmate for some offense in order to give him more time for treatment. Sometimes it is possible to get to the root of the trouble. For example, the inmate may be ill and as a result irritable. In that event the illness should be treated. Or, to take another example, the inmate may be disrespectful to an officer because of worry about some home situation which can be corrected through the efforts of the

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social service department. Obviously, the removal of the worry is the point of attack on the problem.

Next to rehabilitation, correctional workers are interested in research inquiring into the cause of crime, the characteristics of criminals, new methods of treatment, and the effectiveness of various forms of treatment. Unfortunately, most workers are so preoccupied with routine duties that investigative projects seldom go beyond the talking stage. Experiments are apt to be alarming to the more reactionary custodial officers, particularly if such experiments involve the changing of well-established practices.

The various members of the professional and correctional staff are naturally bound together by a certain community of interests. Each, of course, is highly enthusiastic about his own specialty as the panacea for all the ills of the world. Some professional jealousy may arise but, in general, they are tolerant of each other's views and they do present a more or less solid front in their attitude toward custodial officers and inmates, hypercritical of one and over-sympathetic toward the other.

There are, then, three factions in penal and correctional institutions to be considered from the standpoint of interpersonal relationships; namely, the custodial personnel, the non-custodial personnel, and the inmates. Each has a set of standards by which they measure each other. Thus, in the eyes of the custodial officer, a good inmate is one who realizes that he is a wrong-doer and must take his punishment for it. He will not attempt to escape and will obey without question every command given by an officer. The good prisoner will always be respectful to his superiors and abide by all the rules and regulations of the institution. He will work hard at whatever task he is assigned, keep his quarters clean, and refrain from quarreling, fighting, gambling, or any other proscribed activity.

The non-custodial employees have no fault to find with such an ideal. Of course, in addition, the model inmate should take up vocational training, enroll in school, engage in athletics, play in the institution band, attend church services regu-

larly, and send whatever money he can earn to his destitute mother or wife. Above all, he must realize the error of his ways, turn over a new leaf, and resolve to become an honest citizen upon his return to society.

The average inmate does not distinguish between custodial and non-custodial employees. To him, both are on the other side of the fence, representatives of that society which put him behind bars. He recognizes three types of employees, those he can take advantage of, those who take advantage of him, and those who strike a balance between these two extremes. Those who can be taken advantage of are the dishonest and gullible. The dishonest can be bribed to overlook flagrant violations of institutional rules or to smuggle contraband articles into the institution. The gullible, quite innocently, may be lured into doing the same. Those who take advantage of the inmate are the brutal, the sadistic, and the overzealous avengers of an injured society. They take particular delight in reminding the inmate that he is a convict and a pariah, not fit to associate with decent citizens.

The happy median is the employee who is honest, who can not be "played for a sucker," and who is scrupulously fair in his dealings with inmates. He will be stern with those inmates who require sternness, but never cruel or abusive. He will be lenient with those who deserve leniency. He will keep his temper even in the most provocative situation, nor will he lose his sense of proportion. He will not be opposed to innovation purely because it is an innovation. He will not be opposed to making prison a more comfortable place to live in, within reasonable limits, because he knows that most men would prefer liberty to imprisonment in luxury. He will be interested in helping the sincere inmate with his problems. In the last analysis, the inmate will like those employees who will help him get out of prison and who will improve his lot while he is in prison. He will not like those employees who want to give him more time or a "tougher way to go".

A custodial officer who commands the respect of inmates will generally command the respect of non-custodial em-

ployees. In turn, the custodial force will cooperate with the professional worker who does not assume a superior air, who shows a proper regard for custody, who does not meddle with things that do not concern him, and who does not consider himself a heaven-sent Messiah.

The neophyte in correctional work must realize that as long as the public insists upon locking up malefactors custody will take preeminence in penal and correctional institutions, hence those in authority must be custodially minded whether they spring from the ranks of the keepers or not. Therefore, custodial precautions must be accepted as a necessary nuisance, just as shaving every day or taking a bath every Saturday night. One must become patient, taking in stride such irritations as the interminable wait for a custodial officer to unlock a grille door. There is plenty of time in prison, too much time if we are to believe the inmates.

The basis of amicable interpersonal relationships, in prison or out, is common courtesy. The little extra effort it requires pays such big dividends that it is puzzling why so few people cultivate the virtue. Courteousness is not a sign of weakness or servility. It is simply an admission that other folks, besides oneself, are human beings. They, too, have feelings to be hurt. They, too, like to be considered important. They want to be heard when they have something to say, consulted about matters and policies concerning themselves, or at least given some explanation as to why such matters and policies are being put into effect. They are jealous of their prerogatives, defensive of their rights, and sensitive to adverse criticism.

The correctional worker must be doubly careful not to step on sensitive toes, because in a way he is an interloper. He may be met with open hostility, subsurface resentment or, at best, a skeptical sufferance on the part of old-line prison employees. He must sell himself before he can sell his services. First of all, he should not start any project without consulting those in authority. If he can show that such a project will contribute to the efficient operation of the institution—or at

least not interfere with its efficient operation—he will stand a much better chance of securing approval. Second, he will do well to take custodial officers into his confidence, explaining what he is trying to accomplish and how they can help him in the project. After all, they are on the firing line, in constant contact with inmates, hence in an excellent position to sabotage or contribute to the success of any program. It is better to win them over as allies than to incur their enmity. The greatest mistake a neophyte can make is to consider the average prison guard as a “flat-foot” on whom explanations are wasted.

Every employee, whether custodial or non-custodial, must have a sense of loyalty to the institution. It is not only discourteous, but malicious, to carry tales out of school. If an employee sees something that is wrong, it is his duty to report it to the proper administrative officials, supporting his complaints with facts and not just wild accusations or hearsay. A fair administrator cannot take action on mere hearsay any more than a judge can sentence a man for car theft simply because someone says the man looks like a car thief. If the administrative officials ignore a bonafide complaint, then it is entirely in order to appeal to higher constituted authority for action.

Inmates are also entitled to a certain degree of civility on the part of the employees. The inmate is painfully aware that he is a convict. He does not have to be constantly reminded of that fact, nor does it accomplish any useful purpose to do so. He resents being cursed or reviled as much as he resents being cuffed or beaten. If an inmate initiates the abusive language, it is poor judgment to reply in kind. Why should the employee lower himself to the level of the offending inmate? To do so simply invites further trouble, usually ending in physical violence. The employee who takes umbrage easily, or who has to prove his manhood and physical prowess, has no place in prison work. Another source of irritation to inmates is the tendency to consider them as commodities rather than as human beings. An order is given and something hap-

pens to the inmate without any explanation forthcoming. He wants to know why he must do a certain thing, why he must change his quarters, why he must go from one job to another. He will comply with a command much more readily if his curiosity is satisfied.

To come back to the correctional worker, as part of his salesmanship he must be enthusiastic about his product. If he does not believe in what he has to sell, he won't sell it. Practically every correctional worker is fired with enthusiasm when he first enters prison work. His enthusiasm is somewhat dampened when he encounters the inertia of a well-established routine. It may be extinguished entirely when he sees his best efforts wasted on some unappreciative inmate. But that is just part of the initiation. After successfully passing this ordeal, the disillusioned reformer encounters his greatest period of usefulness. Once he returns to an even keel he can concentrate on those inmates who want to be helped, and there are quite a few who do. No one can expect perfect results: there are bound to be failures. Likewise, there will be successes if one keeps on trying. One success will outweigh a hundred disappointments. As the saying goes "There shall be more joy in heaven over one sinner doing penance, than over ninety-nine just who need not penance."

ANTAGONISM TO AUTHORITY AMONG YOUNG OFFENDERS

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The display of unreasonable antagonism toward authority is an aspect of behavior among incarcerated offenders which presents a challenge to those responsible for their care. Without an understanding of the motivation of antagonism and the basic mental mechanisms involved, discipline and treatment of the offending prisoner becomes taxing and uncertain for the institutional authorities. The basic emotional forces at work among those resisting punishment is nowhere more evident than in a prison setting. The reason these forces of the personality can be seen clearly in operation is that the emotional atmosphere of a prison has certain resemblances to the emotional forces in the offenders' earlier home environment. Although the psychological mechanisms underlying unreasonable antagonism are particularly prominent in a military prison, the principles adduced are applicable to the whole field of penology. This chapter is based on a study of service men and their personality reactions in a Naval Prison, yet it also applies to problems of this nature encountered in civil correctional institutions.

Antagonism to authority is a normal reaction in all individuals and derives from the emotional background of the person. It seems to be a constant factor in our culture and is manifest in society through acceptable forms, such as expressed resentment over taxes, dislike of rationing, ridicule of Government heads, humorous sallies at prominent public figures, and small infractions of ordinances. Within limits, most individuals adjust to the dictates of authority by com-

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promise, through a sense of reality about the world around them, and a perception of the need to conform. Open verbal expression of resentment permits the average citizen to adjust to authority comfortably. Normal individuals retain their antagonism during much of their early life, at times extending into adulthood. The point at which antagonism fades as a motive force in behavior in the average individual marks emotional maturity. It is the point at which the perception arises that acquiescence to the demands of authority result in benefit to the common weal.

Antagonism among young offenders in prison, particularly among those in a military prison, demonstrates clearly that the roots of the problem of unreasonable antagonism lie in the early home environment and the relationship between the father and son. The emotional force of the recalcitrant prisoner's antagonism derives from the Oedipus situation and the feelings of power accompanying physiological growth of the maturing adolescent. Those in whom acceptance of authority does not occur are emotionally immature and show by their behavior that they cannot relinquish their infantile relationships. The persistence of this pattern of denial of authority is recognized as a cardinal element in the psychopathic personality. This attitude is not recognized openly by emotionally immature or psychopathic persons, since it is in response to the action of unconscious forces. The immature offender regards his inaccessibility to authority as a virtue. To emotionally immature persons intolerance toward authority is considered characteristic of the triumph of their individuality. This special viewpoint of the immature persons makes for unusual difficulties in the task of giving them insight and modifying their behavior patterns.

The consequences of the attitude just mentioned come into sharp focus in the military services much sooner than in civilian life because of the structure and nature of the Army and Navy. The efficiency of these organizations depends on

the unequivocal maintenance of discipline, and unquestioned acceptance of authority comprises the very matrix of military life. In the military services the open expression of rebellious feelings is prohibited by order, except in the guise of humor or in the perennial "griping" of the American serviceman. The accent on authority as a living force in military organizations complicates the management of antagonistic service prisoners. The psychological situation resulting can best be understood by comparing a military and civil prison with regard to the effect of the authoritarian atmosphere on the prisoners. In a civil prison the disciplinary atmosphere differs sharply from that which surrounded the inmate as a civilian. In a military prison the authoritarian atmosphere is the same as that to which the prisoner was subjected in his previous service life. Whereas the civilian prisoner knows he is leaving a life of freedom with the right to open expression of resentment and *expects* severe curtailment of his feelings, the military prisoner comes to the prison from an environment of discipline and *does not expect* further suppression. The latter feels he has already experienced outside control of his thoughts and feelings to an intolerable degree, and he regards further suppression as more than he can stand. He has been sensitized to discipline already, and has reached a point of intolerance, as judged by the fact of his desertion or other military offense.

The immature service offender can be understood through a comparison with mature men who are able to accept the limitations of military life. This latter group also are involved in the emotional conflict over the presence of authority; they, however, make an adequate emotional rapport with the officers which enables them to absorb their antagonism through humorous references or feelings of loyalty. One often hears young soldiers ask about a newly assigned officer, "Is he 'regulation', *i. e.*, 'is he strict'?" The implied question is: will he "understand" us, will he mix discipline with affection toward us? The good officer perceives this plea and responds with a proper dose of paternal feeling to achieve a harmoni-

ous relationship to his men. The psychological situation in the Army and Navy is such that officers actually come to contribute a paternal environment to the service, and come to embody paternal emotions for the men in their commands. The experience of military prisoners with their officers, whose ambivalent emotions they have already seen at work, even as they have witnessed the ambivalence of their parents, helps them to project their individual feelings to those in the position of authority. There is the added factor to consider that the sailor or soldier was brought into the military situation to safeguard ideals of individual freedom, which appear to him at times to be so ruthlessly thrust aside by rigorous discipline.

The mature man perceives this mixture of discipline and affection on the part of authority in the service as realistically as he did the expression of authority in his early relationship with his parents. The immature man interprets the new authority as "dislike" directed toward him. The reality position of those in authority is confused with the individual's emotional 'image' of parental discipline and punishment. In prison the man who has offended hopes to find a figure who will condone his acts and ease his guilt, thereby projecting from the early childhood-parent situation the wish that the punishing figure will replace hate with love. The wish that authority in prison will be benevolent is the need to overcome an earlier fear of punishment.

The basic emotional meaning of this type of persistent infantile antagonism becomes apparent in the behavior of resisting prisoners. We may read its inner meaning in two types of reactions observed among prisoners. The first of the reactions encountered in serious behavior problem cases or psychopaths occurs in the form of attempts of suicide or self-injury. The second is that of continuous irritation of the authoritarian figure by prolonged and unnecessary open defiance and repeated demands. Both activities have the value of keeping the authorities in a constant position of ambivalence

toward the prisoner. Underlying both is the mechanism which, for the want of a better name, I have called "inverse bullying."

This type of behavior is comparable to that of small children who fantasize the grief their own death will cause their parents. In this way children project their antagonism to their parents as blame, to witness the common expression, "You'll be sorry when I die!" Constant whining demands on the parent, a direct expression of anger, is aimed at maintaining control over those in authority. The same mechanisms occur in prisoners. Both the suicidal and the bullying techniques are unconsciously calculated to arouse the ambivalence and anxiety of the parent figure. This in turn serves to neutralize discipline or punishment, finally evoking parental love and, hence, a continuance of the dependence of the child on the parent. The child (or the emotionally immature individual) must evoke a display of affection to quiet his anxiety. Without this emotional nutriment he could not take the necessary steps in conformance with reality to develop mature behavior. The 'bad' behavior seen on the surface is scarcely recognizable as the continual neurotic preoccupation of the individual with his early conflict over affection from the parent. The striving toward dependence on the parent takes the form of provocative behavior; provocative behavior is interpreted as aggression, bringing forth firmness or punishment on the part of the parent figure. At this point, the situation cannot be recognized as anything but wishful misbehavior and open conflict between parent (authority) and the child (prisoner). The individual offender rationalizes his control of parent figures as demanded by a sense of justice or regards his maneuvers as due to the strength of his own indomitable will. That these behavior patterns are successful in arousing the anxiety and with it the anger of the parental figures (authority) is made clear by the fact of the incidence of disciplinary problems within prisons and similar institutions. Let us turn to two cases which illustrate these types of reactions. The first

one is that of X., whose case illustrates the need to rationalize control of parent figures.

X. was a 19 year old, married seaman, who was brought to the Disciplinary Barracks for the offense of Absence Over Leave of 5 days. He states that he "hated the Navy" and "hated gold braid". He had been in the Navy more than 2 years, having served on the sea most of the time. He had 12 offenses in the Navy, some of them of a serious nature. At one time he was said to have struck a Warrant Officer, and another time he attacked and beat up a commissioned officer while on shore. Although no prison sentence had been served, in civilian life he was arrested 6 times for offenses ranging from vagrancy to suspicion of felony. On admission the man stated clearly that he wished to be discharged from the Navy and therefore went out of his way to disobey regulations. He gave a story which, even if exaggerated, indicated a severe psychopath in whom sadistic elements were prominent. He said his time was spent in thinking, plotting, and planning to kill people with whom he had had even petty misunderstandings. He had a particular dislike for officers, and had already beaten up two of them unmercifully. The subject had numerous contacts with homosexuals in which he robbed them of their money. He said that he felt like murdering anyone whose blood he saw shed. When he tried to stop the bleeding nose of his brother he became infuriated, and a relative watching the episode pulled him away in alarm. There was a possibility that considerable fantasy admixture was present in his story.

In his daily contact with the examiner he showed more anger as it became clear to him that his wish to be discharged from the Navy by breaking rules would not be countenanced. This realization increased his insolence so that he refused to work and from time to time was reprimanded and placed in the Block House. At the same time he showed signs of depression, spoke about crushing his foot under a truck, or cutting off his fingers so that he would be disabled and hence

discharged from the Navy. He said that while on his last A.O.L. he wandered around the streets, sleeping in railroad stations, playing with the idea of jumping under a train to end his life. He wrote his mother saying she would hear from him no more, and he planned never to see his wife again. Shortly before he was apprehended he met a girl who said she had syphilis and he purposely had intercourse with her in order to develop the disease. During our later contacts he expressed strong feelings of debasement, refusing to be treated for a penile lesion in the hope that it was syphilis and that it would invade his blood stream. He said he wanted to live a reckless life, devoted to doing what he pleased without regard to civil authority. He would rather lose a hand than stay in the service and obey the Naval authorities. His attitude toward work in the Navy was fixed: he refused to perform his duties.

The suicidal ideas and self-mutilation tendencies in this case indicate the introjected anger of the prisoner. Direct expression of anger against authority was also present. The emotional depression observed appeared to depend basically on the same mechanisms seen in depressive patients whose destructive impulses toward the external world and subsequent guilty feelings eventuate in self-depreciation and despondency. The prisoner's entire reaction was in response to feeling of frustration evoked by Naval discipline during his two years in the service. The antagonism of the subject prevented much psychological study, but enough material was obtained to indicate his identification with his father and unconscious dependence on the latter. The father had been something of a local racketeer, beloved by his cronies and political friends. A happy-go-lucky individual, the father earned a reputation outside the home of being generous and lovable: yet he never provided for his large family, of which X. was the youngest. It was the ambition of the prisoner to live recklessly like his father.

The second reaction mentioned, namely that of arousing anxiety in parental figures, is illustrated in the case of Y., a youth of 19, a former marine, who was twice incarcerated for

desertion and breaking arrest. On his first admission to a Naval Prison he made a good adjustment. He was restored to duty, but within a month he deserted again. The subject's mother had died during his first period of incarceration, and he felt bitter about the restrictions which prevented his seeing her. On Y's re-entry into the prison, he was noted to be a disillusioned and embittered individual. He was aggressive in his actions, antagonistic toward the officers and his guards, and expressed a violent hatred against the Marine Corps. The clinical diagnosis was Constitutional Psychopathic State, Emotional Instability.

Y's open anger continued to the point of his becoming a most troublesome prisoner. He embarked on a course of behavior which resulted in his being placed under close surveillance. He would not work for weeks at a time, became unruly, threw his food against the wall, was utterly uncooperative. The subject insisted he would not obey any of the rules imposed on him until he could "see them" himself. Discussion only resulted in an impasse, for when rules of the Commanding Officer were cited he would not believe they referred to him. No type of persuasion was effective. When pushed to the point where he could not ignore the facts, the subject at first reacted with psychosomatic symptoms—headaches, fainting attacks, and dizziness which defied medical treatment. Later he became angry, refused further contact with the psychiatrist, and disobeyed rules, which brought further punishment. His disobedience was calculated to be constantly in evidence: he would taunt or strike the guards so that punishment became necessary, and then he would accuse them of unnecessary harshness, denying his own irritating attitude. Segregation only increased his bitterness and added to his complaints of discrimination and threats of suicide. Razor blades were repeatedly found in his cell after it was searched, although only a few scratches on the wrist were observed after four months of such threats. Still the subject was not psychotic.

This type of reaction is very common in a military prison.

There is always a small group who do not accept the need for discipline, deny regulations, and utilize every contact with officers and guards to stimulate punishment which will allow the claim of discrimination. This type of rebellious prisoner is always in the advantageous position of being forced to work against his will, thus assuring himself of a legitimate reason for being rebellious. In actuality, they have "things their own way", and thus indirectly control or modify methods used in handling them. The psychological strategy of this "inverse bully" mechanism is to hold off the acceptance of punishment until the punisher (parental figure) relents or softens. In time the ambivalence of the parent figure is stimulated and his anger decreases; another resolution of the conflict is that the subject is regarded as being mentally ill, or becomes physically sick through the development of psychosomatic symptoms. This latter maneuver again calls for medical attention, which contains the elements of affection or is so interpreted by the subject. The final outcome of this attitude is that authority (the parent figure) may yield to the demands of that portion of the subject's ego which is under the dominance of unconscious wishes and relax the discipline or punishment.

It is evident from the foregoing discussion that the handling of difficult disciplinary cases requires more than routine custodial attention and is a psychological problem requiring study and psychiatric direction. This need for careful planning extends to other types of delinquency and crime, since the same mechanisms are involved in child behavior problems, juvenile delinquency, adolescent misbehavior, as well as in misdemeanors and felonies. The main methods used for controlling persistent misbehavior in penal institutions have been two-fold: deprivation either of food or of the company of fellow prisoners (or both), and treatment by exhortation. The exhortative method, the appeal by argument and urging, is one that immediately comes to the fore in everyone's thinking. It is a paradigm of the time-honored technique by which parents have disciplined and educated their children. Common experience reminds us how universal is the practice among those

who deal with misbehaving individuals to exhort the subject "to be good". Usually the exhortation takes the form of the question, "Why can't you behave?" Exhortation appears to be an almost automatic reaction at first: later it may become a deliberate technique. When results do not follow, deprivation is brought in to reinforce the original demand for compliance.

When one thinks of the emotional problems underlying persistent wrongdoing, it becomes immediately clear that exhortation would be of little value with a psychopathic or immature personality. In the average child or relatively normal adult, exhortation has some effect. In the psychopathic character it does not strike at the root of the psychological situation, which is that of a tenacious clinging to infantile aims and the maintenance of an infantile position with regard to the punisher. The objection to exhortation should not be construed as neglect of the fact that reality demands control of the persistent wrongdoer. What is urged here, rather, is that those who are required to mete out punishment and discipline understand the reason *in* the prisoner for his resistance. It is well for the psychiatrist, the psychologist, and the trained penal worker to know the meaning of persistent defiance to authority, but it is more vital that the guards and sentries who are in intimate daily contact with such prisoners be made aware of the emotional inter-play involved. The rudiments of resistance to punishment is the least one can know if he is to administer discipline effectively. It is sufficient if sentries and guards appreciate only the fact that the defiant individual is looking, as it were, *through* the authority before him and seeing his own past. Those who care for the antagonistic individual must constantly try to picture their charges as children bullying the parent, rather than as the adults which they appear to be in reality. Such an appreciation will be sufficient to lend greater influence to the authority of those in charge. Thus strengthened, the disciplinarian is in a better position to wait until the stubborn prisoner is ready to move from his infantile emotional position to the acceptance of mature values.

Although these mechanisms may appear complicated to those not accustomed to the study of mental life, they may be grasped quite easily if one only resurrects his own experiences in maturing. This is not altogether surprising, since the normal individual has passed along these emotional byways in his childhood. It is, in a sense, a story from the childhood of all individuals: the story of the education of the emotions through which all pass to varying degrees of adjustment and emotional maturity. This kind of personal reconditioning of the prison worker is taxing in its early stages and the strict disciplinarian does not always see its economy when the theory is presented. Without such equipment, however, those who work with prisoners will remain at best only benevolent overseers. There will be no lessening of antagonisms that occur individually or in groups among perverse personalities, and therefore no helpful results to the prisoner from his experience with authority.

REPENTANCE AND REMORSE IN REHABILITATION

WLADIMIR ELIASBERG, M.D.

*Try what repentance can: what can it not?
Yet what can it when one cannot repent?*

HAMLET, III, 3.

It has often been shown that the more humanitarian tendencies in penology, the restriction of capital punishment, the abolition of mutilation and the other corporal inflictions, were based on a certain philosophy and a certain psychology, both developed by the end of the sixteenth and the beginning of the seventeenth centuries. Serving a prison term could become a competing form of punishment only after correction of the criminal had become a goal of the same dignity as vengeance and retribution. At the same time, in the Catholic reform movements, in Loyola's Order of the Jesuits, a psychology of meditation, concentration, and deliberate direction of the mental processes was developed. The Catholic Church could make use of a rich stock of psychological insight built up since the time of St. Augustine, developed by St. Francis of Assisi, and practiced day by day in the confessional.*

But there sprang up, also in the seventeenth century, among the Puritans, Quakers, and other Protestant denominations, a psychology of musing, contemplation, repentance, and mending one's ways.

Whatever the meaning of repentance—and we will see that there are very many meanings—this much is generally agreed upon: it is a matter of subjectivity. However, ours is

* Repentance, as a preparation for receiving the sacrament of absolution, was defined by the Council of Trient as: "Animi dolor ac detestatio de peccato commissio cum proposito non peccandi de cetero" (Mental anguish and execration of the sin that was committed, accompanied by the intent not to sin again). *cf.*⁶⁴

an age of objectivation, in psychology in general, in sociology as much as possible, and in probation work almost exclusively. The progress, if any, that was reached in *Criminal Careers in Retrospect*²⁸ seems to be based on a determined turn to measurable facts and the statistical account thereof. We read of the religion of the offenders as a punchable fact. We do not read of religiousness (for criticism of statistics in criminology, cf.^{34,56}).

Nor is this the first time that the subjective aspect of mental life, and repentance in particular, has fallen on evil days. For Spinoza, the only virtue worth striving for was the realization of one's own personality and mind. In this way alone, the individual could do what, from the deterministic angle, he must do anyway; namely, fulfill the attributive movements of the only substance, God. Repentance from this viewpoint is "sadness accompanied by the idea of a deed which we believe to have done through free decision of the soul." From the angle of determinism, it is a silly idea.**

Quite similar, although encompassed in another philosophical system, is the viewpoint of Schopenhauer. As will is the real substance of the universe, and by dint of volition alone we partake in the true reality, we may feel pangs of conscience, or rather the anxieties of conscience, if we are too weak to play the role for which we are destined. Repentance may occur only if we contemplate the deviation, in our action, from the volitional cynosure, that is caused through the interference of mean reasoning and understanding.

Modern psychology may harken to the great and uncovering dreams of philosophy. It should, however, proceed on its sober way of empiricism.

Empiricism and experience are by no means identical with statistical experimentalism. There are things that we cannot experiment upon without destroying the substance that we would like to know. Dissection cannot be the only basis of

**That is, a deviation from reason, while reason alone can help us achieve what fate has in store for us. With less emphasis on the deterministic angle, this was already Socrates' idea. cf.³⁸ p. 123.

physiological and biological experience. The modern psychological investigation of such phenomena as religious experience, repentance, or guilt, has been based on the questionnaire method, which seemed to obviate certain of the difficulties of the experimental method in the narrower sense.^{43, 24, 30, 64, 20} These difficulties were discussed by Girsensohn, who himself was an enthusiastic pupil of Kulpe, the father or reviver of the introspective experimental method. As to the history of this method, compare E. B. Titchener⁵⁵, W. Eliasberg¹⁷, S. Behn⁴. The introspective experimental investigations in the narrower sense had to be conducted with more or less psychologically trained subjects of a relatively high ethical and moral standard who were willing to give their time, their honesty, and their mental energy to promote scientific interests. But even under such conditions, phenomena such as repentance and remorse could not well be attacked because the true conflict to which repentance should refer could not be provoked experimentally. One might think, though, of such experiments as were carried through by K. Lewin and his pupils, especially Dembo, on annoyance⁷, in which the subjects were given assignments which seemed to be solvable but actually were not. The reactions were observed and interesting phenomena, such as aggressiveness against the experimenter, regression of reality level, regression in the analytical sense of the term, were noted. A somewhat shallow repentance, observable in the context of such experiments, might be produced. Anyway, for the population of a prison, such experiments are out of the question because neither the honesty, the average intellectual level, nor the aloofness and disinterestedness necessary for such experiments can be assumed to prevail to a sufficient degree.

How about the questionnaire? Those authors who worked with the questionnaire method, especially Moore⁴³ and Ensslen²⁰, have noted that there are certain advantages. First of all, the repentance which the participant (no longer called subject) remembers is a true occurrence. He may turn to it in moments of contemplation. He may give it full considera-

tion and the written expression will not so much depend upon the inspiration of the moment. He has more time to revive in himself the original occurrence, to glance at the various aspects, etc. But here again, disinterestedness is necessary and we will see later to what degree the method is applicable to prison populations.

However, there are objections on principle against the application of the questionnaire, as well as the objectivating introspective method, where the experimenter compares the data furnished by the consciousness of several observers. This objection is that fifty percent—other critics, possessed of more largesse, say four fifths—of the mental life is unconscious or subconscious and that the most honest introspective observer does not know anything about the true dynamics of his mind. In experiences of such a delicate order as conflicts and repentance the percentage is even more unfavorable, they would say. At first glance, the objection would be justified if one reads the papers so far published. They contain classifications and at times very refined descriptions. But remarks as to dynamics, even those which the subjects hint at, are not grasped or discussed by the experimenter. Thus Maria Moers will elaborate on the component parts of repentance as emotion, will, intellect; on the related genera as pangs of conscience, feelings of guilt; on the motives as fear of punishment, self-contempt; relationships between repentance and other experiences as will or intent to improve; relationship to God and religious ideas to self-respect, to contemplation. There is also a discussion of whether the bad intent, if it leads to something which is not morally objectionable or even good, will be felt as something that requires doing penance. This, incidentally, is the old Mephistophelian problem.

Part of that power not understood which always wills the Bad and always works the Good.

Where the author discusses repentance, she deals with what the subjects, each one isolated at his desk, have dealt with, whether repentance is a negative or positive value in life for the

one who experiences it. It might be noted that about eight years after the Treaty of Versailles, when Maria Moers questioned her German subjects, none of them discussed the question of whether a nation could be guilty and should or could do penance. This attitude, though, was very familiar to the middle ages, when whole cities, communities, and even the Roman Catholic Unity of Nations were willing to assume the attitude of either the recluse doing penance for his sins, or the Knight Errant fighting against the sins of the world.

When such authors as Maria Moers, Wunderle, Ensslen, glance at the wholeness in which such highly delicate and personalized experiences have their roots, references are made in rather vague manner to the structure of the personality, and neither cultural nor historical, let alone anthropological or ethnographic, differences are mentioned⁶³. Also the pathology is left out. The latter, in particular, would have forcefully imposed upon the experimenter the necessity of turning to dynamics.

At present, however, dynamics is more a program than an implemented knowledge, and what is available in tools is handmade by certain experimenters, whose ingenuity often consists in making good for the imperfection of their tools. This state of affairs must be stressed because the second and third generations of votaries of psychoanalysis seem to think that the problems involved here have all been solved. The dynamic viewpoint has proven even more fruitful in illegitimate, as it were, applications. Thus one has followed Calvinism, Quakerism, and their secularization in modern business ideology down to their roots in feelings of guilt, bad conscience, need for security and protection, and fear of death^{58, 44}.

The dynamic viewpoint in confession and repentance may be traced back to Aristotle's concept of the tragic catharsis: communication of the secret purges the guilty man and his society. Reik has shown that an urge to confess is attendant upon repression⁴⁶. In fact, this urge accompanies us so long as the voice of the superego is not absolutely dead²². In his book, Lindner⁴⁰ has taken up the question and has shown that

the patient's urge can be helped skillfully, and that hypnosis, far from destroying the power of repressing instances, can help them. While here a step ahead is theoretically taken, we will, in practice in the penitentiary, have to rely on measures which can be used without too much cost in time and attention on the individual criminal.

The real purpose of this paper could not possibly be to deceive the reader about the imperfection of the present stage. It must be to show how, with what is offered him, he on his part may contribute towards the better knowledge of what is generally assumed to be a strong lever in the life of the individual as well as in the history of the moral development of mankind, and may again become a factor in our day by day evaluation of the prognosis of the criminal.

The problem in the American prison at the beginning of the nineteenth century was to lead the prisoner to true repentance as a guarantee for his reform. This was also necessary to appease the theologically motivated feelings of vengeance, etc. There was not much understanding either of the social psychological situation of the prison or of the personality of the evildoer. Our modern ideas of whether repentance is desirable must be based on understanding and the probable responses of individuals placed in this situation.

Turning to the methods applicable for the gaining of such knowledge, it must be stated first that the valuable part of the older literature, namely, the memoirs, the diaries of eminent individuals, poets, writers, and average individuals who were questioned or wrote diaries have not been rendered useless through what is at our command in modern sociology and psychodynamics. The picture in Dostoevski's community of prisoners *in statu nascendi* has not lost its realism¹⁰. It is not only "united we stand" (against the superiors); it is also a unity of negative character, of hatred, of lust for destruction, etc. Such groups, bound through negative feelings only, are very well known as the addressees of modern political propaganda, and with their rash actions, panics, and explosions we have become familiar by now. Dostoevski's description of

the uncanny influence of "public opinion" in the jail, of the subservience of the most ruthless inmates to the spirit of the group, is well borne out by experiments made time and time again in American penitentiaries. There is, on the other hand, according to the type of prison system, a certain tendency to isolation within the prison group, with or without sexual background⁸. We have, furthermore, to bear in mind those more or less fantastic spiritual developments which we see among prisoners in the Tombs awaiting trial (Untersuchungsgefängene) or prisoners in the death house, or finally, among lifers. The common factor in the situations of these three groups is that they have obviously lost their bearings as regards the real world: the prisoner, before trial, and under the influence of strong emotions and the urge for self-protection, the inmate of the deathhouse, under similar influences, and the lifer because of the loss of libido that would find objects in reality.

It is among these definitely pathological⁶² or at least "de-realized" men that we often meet with religious developments or characteristic forms of contrition. Such cases have been described by Arthur N. Foxe²¹ and by me²⁰. My case, a young farmhand, was arrested in 1926 on suspicion of having murdered a child. He was sentenced to death, and after the execution it was found out that another man had committed the crime. While in the Tombs he wrote down his ideas. There is one, which in its simplicity is touching: 'If man is lonesome and abandoned, then he becomes aware of what man's life is'. In Foxe's case, it is particularly interesting to note that while there is a gradual turning to Christ and a gradual awareness of the futility of life as it is lived by so many futile human beings, there is no word of compassion for the victim. He goes to death comforted by religion, but he does not bother about the murdered man.

A good survey of the older literature on biographies and memoirs was given by G. Radbruch^{45*}. Whoever wants to make use of modern methods, should be familiar with that older literature and should have a general understanding of

* A criticism of memoirs and their reliability will be given later.

the background of the prison. Among the most important tasks, we have been told, is the differentiation between true repentance stemming from true contrition and leading to the will to do penance and that attitude worn as a mask for the purpose of securing some "earthly" advantage. But there is another differentiation, quite as important as the first: that between normal and pathological repentance and remorse. The high incidence of states of depersonalization, of de-realization, of losing contact with the world, of building up fantastic delusionary ideas, was already mentioned. There are also true psychotic states. It should be noted, however, that the self-accusations and self-incriminations of true melancholia are not built up to the intent not to sin again ('decetero'). For all the substantiated bill of counts they may contain, they do not resemble any too much the self-accusation of the repentant. The two should not be confused.

In the post-war period W. Luz⁴¹ published a book in which he used a questionnaire filled in by prisoners and compositions of prisoners who had confided in the chaplain. The constructive criticism of this method will be developed later. Suffice it to say that because that material belongs to a certain type of memoirs, written by political prisoners, poets, or just average prisoners, its reliability has to be determined.

There are certain resemblances and differences between pathological repentance and pathological confession. The latter does not occur so often among melancholics who lack the energy to go out and establish contact with authorities. Pathological confession is rather the field of hysteria, paranoia, incipient paresis, incipient paranoid schizophrenia. The methods to deal with this are those of the psychiatric hospital and they must be reserved to trained psychiatrists.

The other problem, that of differentiating between true and feigned repentance is a psychological one. It is not all so simple, however, as is implied in the dichotomy truth-lie. We will understand that best if we look for neighboring opposites. In the investigation of guilt feelings, one has found out that strong feelings may be attendant upon slight "objec-

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tive" guilt, *i. e.*, upon rather unimportant effects. On the other hand, Dostoevski has shown in the character of Ras-kolnikov the strong feeling of guilt with no repentance. This is even the most frequent type. The murderer may feel himself shadowed, his conscience will speak but it will not tell him to repent.

*"Forgive me my foul murder
That cannot be; since I am still possess'd
Of those effects for which I did the murder."*

HAMLET III, 3.

In other words, in normal psychology also, it is the personality patterns (or patterns derived from the individual's group) that determine the intensity and direction of the guilt and repentance. This has appeared particularly in those investigations where the participants or subjects were Catholic priests. It seems as though repentance is "worked up" most easily where it is a ritualistic pattern and, as such, a regular occurrence. But this, of course, has quite a different meaning from the criminal's repentance, which refers either to the last crime or to some other crime or to some latent feeling of guilt or to some ill feeling rife in the particular society. Still, even in the latter case, the automatic repetition, the working up of guilt and repentance in the context of ritual, is lacking.*

It is advisable to distinguish repentance according to the stages in the judicial process. Repentance may occur in the preliminary stage (Untersuchungshaft). It may occur during trial⁶¹ and while the convict is serving his prison term. In each of the stages, there are characteristic influences and reaction types. Those of the isolation in the Tombs were al-

- * For this type of work-up repentance, see the word of Mephistopheles:
She is coming from confession,
Of every sin absolved.
So innocent is she indeed,
That to confess she had no need.

This, however, is not likely to occur in the American prison. The already mentioned memoirs of prison inmates, published by Luz, are somewhat in this vein. The individual rages against himself. "Yes, I did it, and here I am, and it all goes back to my early childhood when I despised the teachings of my pious parents, teachers, etc." This is a point for the unreliability of the memoirs and shows the influence of the prison chaplains.

ready mentioned. There are, in the preliminary stage, strong influences brought to bear upon the subject by police and prosecution to get a confession. It has not been investigated, however, how in the preliminary stage the confession pressure influences the inclination to repent. Wimmer⁶¹ has developed a phenomenology of confession, repentance, or denial during trial. The courts usually press the accused for a confession and the usual assumption is that he will get a more lenient sentence, because confession in court, a process which is against the instinct of self-preservation, is by the same taken to be a sign of repentance. Apart from the fact that there may occur pathological confessions in the trial stage, confession and repentance in trial are often used by the defendant as a weapon. He may hope to get away with it at least practically, so the whole thing is couched in a rather equivocal psychological situation and, taking confession and repentance at their face value, should remain buried together with the inquisitorial era of the trial.

With the whole complexity of the repentance phenomenon, its roots in the individual and his society fixed in our minds, we may now turn to the method which might be applied to induce true and active repentance and to judge the attitudes of the prisoners for probation, prognosis, etc.

As a first step, we may use those tests which were developed in the rough statistical studies of Sheldon and Eleanor Glueck and the Illinois State Commission on Probation⁵³: age, social background, family background, intelligence, schooling, training, age at first offense, etc. If the prisoner, on the basis of the statistical data, is deemed to be a good prospect, and if the psychiatric examination shows no striking pathology, then he may be given a work-up along the following lines.* For the selection of the methods, the following factors were deemed important: A. Reliability of the single method and the whole battery; B. No intricate apparatus should be neces-

*This work should be done in a team, where the warden, chaplain, workshop supervisors, foremen, teachers, social workers, psychiatrists, psychologists, and physicians, should cooperate.

sary; C. The methods should be applicable for both individual and group work; D. No introvert trend should be given to the examinee: he should, on the contrary, be given a push toward the outer world.*

On account of unreliability, a method has been discarded which enjoys a certain reputation among counsel and the courts. The expressive movements are falsely deemed to be objective. Even a certain position of the fingers while taking the oath is not so unrevealing as counsel thinks. But these expressions become quite incomprehensible if one is not familiar with the personality. Leonhardt, a German judge, has published quite a lot on the understanding of the expressive movements out of the whole context^{36, 37}. While this is a certain advance beyond the crude interpretation, the reliability is by far not sufficient.

First, after the usual intelligence examination, a Rorschach should be given, shortly after admission, and the results compared with later ones³⁹. In the same way graphological samples should be secured shortly after admission and later. The graphological method has certain advantages over the Rorschach^{11, 12}. It is independent of verbalization, because the same traits that are decisive for the graphological diagnosis can also be elicited with senseless scribbling, as in the Mira experiments⁴². In the Rorschach, the materials are less coherent than in handwriting and the scoring is therefore more arbitrary.**

If the prospect, on the basis of these experiments is still bright, the inmate may be given a questionnaire which he should fill in in some "study period". While this questionnaire should be filled in with some contemplation, care has been taken in giving the questions such a wording as will not induce too much introspection, let alone introversion. Here is a sample of such a questionnaire. There should be different

*This is why in the following list personality inventories, such as the Bernreuter, or any methods using self-analysis (Horney), have not been recommended. *cf.* ⁴⁰.

**Handwriting also may reveal or lead to suspicion of neurological difficulties.

forms, according to the mentality, intelligence, and rural-urban surroundings.

QUESTIONNAIRE

1. Did you ever repent what you did?
2. Do you remember regretting something you did in childhood, adolescence or later years? Give examples.
3. Were these feelings strong feelings of repentance?
4. Did you regret a particular action of yours? (Was it connected with a particular occurrence?)
5. Does it turn up in your mind again and again?
6. Did you have that feeling before doing it, while doing it or after doing it?
7. Was that feeling very bad?
8. Did you feel hunted at that time?
9. Did you wish to have the feeling of repentance or did it come without your will (Like pangs of conscience)?
10. Do you recollect your deed because something keeps bringing it back to you (were there particular experiences that revived the recollection)? Did it come back to your mind because you had to pass certain localities, came across certain persons, etc?
11. Did you want to make good the harm you did? (Did you want to do penance)?
12. If your action was intended to be bad, but there was no bad effect, did you nevertheless regret it?
13. If you feel your life is not good, whom would you blame?

In the directions, the inmate should be requested to read carefully and to give the questions some thought. He need not, if he does not want to, fill it in in the same "study period". He might do it the next time. If he wishes, he may answer only one of the questions. He should particularly do so if some concrete example is clear in his mind. The atmospheric conditions in which such a method can be carried through, will be discussed in our concluding remarks.

From the standpoint of the psychologist, this questionnaire certainly would not be complete. However, it is not intended to be. It should be borne in mind that the questionnaire is the most unreliable method, but for reasons quite different than prevail for the Auto-Pitivals. The academic stan-

dard of a prison population is usually rather low (Gault, p. 131). Answers may be poor because of difficulties in verbalization. It would not even mean too much if the questionnaire was returned without an answer altogether. At any rate, the questionnaire must be followed up in interviews, wherein care must again be taken not to chase an inmate into the den of introversion, or, on the other hand, to encourage hysterical demonstration. For the difficulties involved see Richmond⁴⁷, Rogers⁴⁹, and Young⁶⁵.

Those inmates who have qualified in the preceding steps may then be gathered into groups with as much self responsibility as possible. The group method of psychotherapy in prison has not been altogether neglected in practice. There is a critical report in Barnes and Teeters², p. 547 ff., which is useful for our purposes. The reformatories in America had to struggle against the old prison discipline, which apart from everything else it did, isolated the individual prisoners. Keeping in mind the experiences in Elmira and carrying enthusiasm from the Youth Movement, Hermann worked in a Hamburg prison for youthful offenders (Hahnofersand)³¹. M. Liepmann, the German criminologist of the pre-Hitler era, wrote a comprehensive introduction to the book in which he gave much praise to the American experiments³⁸. The idea was to keep up discipline and at the same time to have as much self-government as possible. In this way, esprit de corps and feeling of responsibility for the collective should be created, while the prisoner's own will should not be sacrificed to a system of iron discipline. It is interesting to note that the prisoners were also encouraged to read papers to their mates. In this way, the collective was able to enlarge its knowledge. There were discussions of the news carried on by the whole group under the supervision of the author of the book.

Theoretically, the problem of collective treatment and therapy in jail has not been worked out satisfactorily. It is quite clear that, on the whole, group therapy is the only one that will be feasible. Encouraging as they may be, experiments

such as that of Lindner⁴⁰ cannot be carried on for any length of time or with any considerable number of prisoners.

Collectives in *statu nascendi*¹⁰ have proven valuable for propaganda and other purposes which are themselves in *statu nascendi*. However, the group that will serve the purposes cannot be entirely new psychologically or sociologically. It must be homogeneous as far as possible with respect to sex, social background, social rank, rural or metropolitan influences, and last, but not least, criminal record (first offenders, second offenders, persistent offenders). If we consult experiences with psychotherapeutic groups, we will deem it unfeasible to treat social maladjustment of the criminal type in a heterogeneous group.

Best results will probably be achieved in the youthful group as described by Herrmann³¹. The size of the group may also be important. Sub-groups should be formed, *e. g.*, for the purpose of collaboration on some practical question or for the preparation of a lecture. For this purpose they should be given a certain modicum of leisure and be allowed to convene privately. The objection to that would be that such groups might be used for the formation of gangs and rackets under the eyes of the authorities. This objection, however, does not hold water. We assume, of course, that the atmosphere in the prison is not that bad. For this reason, new admissions should not join the groups until they have been passed upon by the board.

Furthermore, on the basis of experiences in the psychotherapeutic group¹⁹ the following principles should be observed: The participants must be willing to give up their privacy in the same way as the members of a psychotherapeutic group do before entering the group. This should not be too difficult to achieve. The participants should prepare reports on either more theoretical social and economic subjects or tell the group of their experiences as workers, unemployed, members of criminal gangs, etc. Topics could be, among many others, alcohol, venereal disease: Why I drink more than I like, etc. The prison library should contain source material. A psychia-

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rist well trained in psychodynamics, social psychology, and knowing something about sociology and economics should be the moderator in this "seminar".* His neutrality in the class struggle and other social problems of importance must be kept beyond doubt. It is not the class struggle that can be "abreacted". In such seminars new insights can be developed which can then be worked out further in more private conversations and given the form of regret and repentance. The group itself learns in a way which has been dubbed, since antiquity, the Socratic method. They will learn from each others' life experiences, not through definition of concepts, but through a kind of empathy, some guided emotional understanding of each others' problems. At the same time, while the interpersonal relations develop, there is also better transference to the moderator, and, finally, owing to the topic, there is a direction toward abstract thinking which is very important in order to counterbalance the mere fixation on the leader. Democratic life, politics, and economics** are in need of a balance between abstract and concrete attitudes and it is particularly among youthful offenders that very often the overwhelming influence of tangible social influences, in other words, the bad example, leads to crime. The moderator should often try to step back behind the topics being discussed. The result will be a strong in-group relationship with very little out-group aggressiveness, and a strong tendency to look over the fence. Understanding of one's self is a desirable side-effect of this process, which can be reached in this way much better than with merely subjective pondering over one's self. In traumatic neurotics it has been found that the participants not only learned to adjust themselves to the seminar groups but when they came back to the job there was less friction without meekly yielding. Once such a group functions, it is not very vulnerable to turnovers in manpower, provided the homogen-

*A Seminar of Living, if a name is necessary.

**The Germans in the First World War failed to build up morale because their Vaterlandischer Unterricht was only abstract propaganda delivered by officers in the form of lectures. Owing to its abstractness, that was no remedy for the lack of love (Lieblosigkeit) which Freud mentions as a strong destructive force in modern society.

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eity is not troubled.* It is strongly recommended that group psychotherapy should be given earnest consideration. It is hoped that reports will come in. This author is willing to make such reports available to those interested.

Repentance has proven to be a strong lever in the history of mankind. In the prison of the nineteenth century under entirely changed conditions of immeasurably increased competition, social distance, social temptation, etc., there has been little opportunity to see what it still can do. In the meantime modern psychology and modern sociology have given us new sounds with which to plumb those depths where the human soul gloats over its triumphs or pines with self-destructive remorse. The great discovery for criminology is that while remorse and self-incrimination will not guarantee true reform, rehabilitation may come from the will to live again in the community, to make good for harm, and to look critically at one's own life and goals. In the memoirs, we have seen how single individuals have been able to gather new strength of the mind from seclusion. The modern prison, based on modern psychology and sociology, should strive to bring the combined forces of introspection and extraversion within the reach of the average prisoners.

*Apart from non-homogeneity in age, social rank, criminal record, certain prognostic factors may be derived from the characteristics of the prospect. It should, however, be kept in mind that a working group is an antidote to certain characterological difficulties. Therefore one should not eliminate beforehand the autistic personalities, split personalities, etc Cf.^{50, 50, 35}

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THE UNDERSTANDING AND MANAGEMENT OF GASTRIC NEUROSIS

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In the present paper the term "gastric neurosis" will apply to all those dyspepsias which are primarily emotional in origin. From the standpoint of the internist this will include such conditions as acute and chronic gastritis, hyperchlorhydria, duodenitis, and peptic ulcer, providing that the cycle of physiological and anatomic disturbance has a predominantly psychological basis. This diagnosis cuts across existing psychiatric categories to indicate a specific type of emotional conflict, resulting in gastric symptoms, which may occur in psychoneurosis, psychosis, or in so-called normal people. The fact that most sufferers from gastric neurosis might be described as having an "obsessional" character structure does little except underline the enormous incidence of this condition, since the average person in present-day Western society may also be described as an obsessional character. In particular, anyone who has listened to a radio or read a newspaper in the United States is aware of the extent of dyspepsia in this country, and the eagerness of the drug firms to exploit the situation.

No other psychosomatic disorder illustrates quite so well the complex interrelationships between the psyche and the soma; in fact, it has taken the coordinated researches of gastroenterologists, psychiatrists and psychologists in the past ten years to furnish us with some understanding of the disorder. In 1934 Alexander and his associates at the Chicago Institute of Psychoanalysis reported the results of psychoanalytic studies on 9 gastric cases, 6 of whom had been diagnosed by X-ray as having duodenal ulcers¹. Alexander demonstrated that while the "gastric type" generally presents an intensely ambitious, energetic appearance, he is forced constantly to oppose or repress his own less conscious need to be taken care of. In

Freudian terms this conflict is described as "the rejection of strong oral-receptive tendencies on account of their incompatibility with the aspirations of the ego for independence and activity." Alexander suggested further that the less conscious dependent needs are expressed physiologically by overactivity of the stomach which behaves, during those periods when the ego is assailed by internal or external reverses, "constantly as it does during digestion".

Mittelman and Wolff corroborated these findings in a study of 30 unselected cases of peptic ulcer and 3 cases of gastritis and duodenitis⁵. In addition they learned that only the specific emotions of anxiety, resentment or hostility produce the rise in gastric acidity and the increase in gastric motility which cause symptoms. When these emotions were replaced by feelings of well-being, the gastric physiology returned to normal and the symptoms disappeared. Wolf and Wolff made similar observations on a patient with a large gastric fistula⁶. Whereas such emotions as fear and sadness were accompanied by a pallor of the gastric mucosa and by an actual inhibition of acid secretion and contractions, anxiety, hostility and resentment, on the other hand, were accompanied by accelerated acid secretion, hypermotility, hyperemia, and such an engorgement of the gastric mucosa as to resemble hypertrophic gastritis. When this state of emotion was sustained, the most trifling trauma was sufficient to induce mucosal erosions and hemorrhage. Contact of the gastric juice with this eroded area accelerated the secretion of acid and mucosal engorgement, and prolonged exposure resulted in the formation of a chronic ulcer.

To recapitulate, psychoanalytic studies first gave us a dynamic picture of the "gastric type" of personality and suggested the kind of conflict that would result in symptoms. Later physiological work, more microscopic in character, revealed the effects on gastric physiology of the specific emotions which accompany such a conflict: anxiety, resentment and hostility. The present paper, based largely on a study to be published of 146 hospital cases of gastric neurosis, not only

corroborates the above findings but may serve to indicate a more specific etiology, and in particular to suggest means of correlating this understanding of the gastric personality with practical measures of hospital care³.

The psychopathology of gastric neurosis can best be presented by means of a hypothetical case history, embodying the most conspicuous features common to all cases. Obviously, no two individuals are alike, but it is possible to imagine a composite character, J., who will probably be recognized by most physicians as bearing some resemblance to the gastric neuroses he has encountered.

J., aged 28, married, entered the hospital because for three weeks he had felt bloated, with occasional sharp cramps in his upper abdomen. Although he seemed to crave food, he had noticed that every time he sat down to eat his appetite disappeared, giving way to nausea and often vomiting. Alkaline powders, sedatives and antispasmodics had given him little relief. His physician had suggested hospitalization because he thought X-rays of the stomach were indicated, and also because he thought enforced bedrest in a neutral environment might be helpful. He had surmised vaguely that J. was "nervous" and had strongly advised him to "take things easy, relax". J. remarked, "I try to relax but I can't. I go to bed every night at 9, but I can't sleep."

No comment is necessary about the above advice. If relaxation were so easily manipulated by an effort of the will, therapy would indeed be a simple thing, hardly calling for medical intervention.

On first glance J. looked older than 28. His hair was prematurely grey, and he was quite serious in manner, rarely smiling. Nevertheless, his face was boyish, almost too boyish considering his position as assistant office manager for a local construction company, with some fifteen stenographers and bookkeepers working under him. Immediately he explained to me his responsibilities to his company. He wanted to know definitely when he could return to work so that he might notify his boss, the office manager. J. had been with the company only 5 years, but his progress had been so rapid that he was regarded as "the boy wonder" by older employees. About a month ago his boss was called

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up for induction into the Army, and there had been some excited discussion about J.'s replacing him. J. freely admitted his disappointment when the boss was turned down, though he assured me that he "had nothing against him. He's been swell to me right along." When asked if his disappointment could have anything to do with his stomach trouble, he said "Maybe, but I've had plenty of stomach trouble before".*

He recalled that as a child he was often nauseated following arguments or quarrels with his schoolmates. Riding as a passenger in automobiles, street cars, buses, or trains nauseated him, although driving his own car gave him no trouble. Once at a summer camp, where the boys had to line up for meals, he had a number of vomiting attacks while waiting in line. Even now he tried to avoid restaurants where the service wasn't prompt, and preferred cafeterias where one could wait on himself. However, all his early episodes of indigestion were brief. It was not until his last month of grade school, during his apprehensive preparation for final examinations, that he was forced to go to bed with what was called "ptomaine poisoning" by the family physician. He managed to make up the examinations during the summer and to maintain his scholastic position in the upper third of the class.

Considered rather small for football, he had nevertheless gone out for the team in high school and made his letter as quarterback in his sophomore year. During the "half" of practically every game he was seized with epigastric cramps and nausea which he relieved by vomiting. The school physician urged him to give up football but he refused; he also persuaded the physician not to tell his mother about his indigestion, since she worried about his playing anyway. At the end of his second year he found a job as wrapper in a department store. He did not return to school in the fall, having convinced his mother that he could learn more by working and attending night school. He had no severe indigestion at his job until he discovered that the salesgirl he had been dating was also going out with one of the men in his department.

It can be seen clearly enough that in each instance indigestion was provoked by a competitive situation—scholastic, athletic, economic or sexual—in which he felt his efforts

*In the above mentioned study of 146 consecutive cases, 52% were found to have had symptoms most of their lives.³

toward independence threatened. For the individual with a gastric neurosis life consists of a never-ending series of examinations, most of them self-imposed. And one is struck by the pessimism with which he approaches each new examination. Regardless of how successful he has been in the past, he tackles the next obstacle as though failure were a certainty and success a phantom never really secured. What seems most evident in this restless struggle for independence is the insubstantiality of feelings of self-esteem; they must be endlessly nourished by new accomplishment. Situations of enforced dependence are tolerated as poorly as actual defeat: waiting in line for food or being the passenger, rather than the driver, of a vehicle. In this connection, it is interesting that a considerable number in the group mentioned above had chosen cooking or operating a public vehicle as their profession³.

In a sense no group is more precocious than the gastric neurotics. They are the "little soldiers" of our society, who seem to have altogether by-passed childhood; yet, indirectly, childhood is always with them. Even while they are belligerently refusing anything labelled as support, in many unrecognized ways their demands for help are insatiable.

While he worked for the department store, J. had a number of sexual experiences with various girls in the store and occasionally visited houses of prostitution with his friends. Several of the latter experiences were followed by indigestion. With girls whom he regarded as inexperienced or "immature" he was able to have coitus without symptoms, but he was more attracted by older women. "I seemed too old for the kids my age. We didn't have anything to talk about."

At 20 he was married to a girl four years his senior*, a buyer at the store. On his insistence she left her job and devoted herself to taking care of their home. "I never did approve of guys letting their wives work." Mrs. J. never proved to be as proficient a housekeeper as he would have liked. There were numerous quarrels over the cooking. Nor did he approve of her shopping, and he soon took to buying all the food himself, concentrating on choosing a

*One-third of all the married patients in the study had older women as wives.³

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wide enough selection so that they would each have what they liked. When angry, he would remind her of how much he did around the house after he had worked hard all day. She, in turn, would remind him that she had never cared for housekeeping anyway and wished she could go back to her old job. J., who never agreed to this, suffered from dyspepsia after each quarrel.

After they had been married two years, Mrs. J. became pregnant. The whole period preceding and following childbirth was a difficult one for J. from a digestive standpoint. He was under the care of his physician much of the time, missing several weeks from work. In his relations with his wife he became even more solicitous than usual, and as she approached her delivery he insisted that she spend the last few weeks of pregnancy in bed. It was at this time that he became dissatisfied with his job and transferred to the construction company, which offered more opportunities for advancement.

His wife's inability to breast-feed the child was a great disappointment to J., who had heard that breast-fed babies were healthier. Almost from the beginning the baby was a "feeding problem". J. blamed his wife for not following the schedule provided by the doctor, and whenever he lost his temper he accused her of being too selfish about her own comforts to care for the child properly.

The fact that he longed for a kind of maternal devotion from his wife is evident enough. Not quite so evident, since her supposed inefficiencies were usually the cause of their quarrels, is the manner in which his own anxieties anticipated and even frustrated her maternalism toward him. Much of his activity about the house, such as the shopping, held a note of reproach. He wanted to do it, so that it would be done "properly", but nonetheless he felt that if she were any kind of helpmate she would be doing these things for him. Even as he took the responsibilities out of her hands, in other words, he resented the fact that she allowed him to do it. Leaving aside the wife's problems with her own femininity, we can still assume that no matter how ideal a housekeeper she might be, he would still be forced to see her in a somewhat ungenerous light. It is to be expected, therefore, that he would be similarly concerned over the care and feeding of the child.

Some gastric neurotics achieve a more satisfactory marital solution by finding a new partner who has less conflict herself over being maternal. Alexander mentions a patient whose symptoms disappeared only after he had left his wife and established a relationship with a more maternal woman, quite the opposite of the wife in temperament¹. In many cases, however, no amount of marital reshuffling seems to produce any therapeutic effect. Another patient married a buxom matronly woman who showered him with attentions which he soon began to interpret not as love, but as possessiveness. Characterizing her in his own mind as a jealous woman who resented his freedom, he divorced her while almost bedridden with symptoms. His next wife was a younger, more coquettish, certainly less dependent individual, who resisted all the housewifely accomplishments and fought for her own freedom. This marriage also terminated in bitterness, indigestion and divorce. After that he lived in a boarding house where a kindly landlady provided for his daily needs, without particularly disturbing either his independence or his dependence. Still another patient had had almost continual indigestion while married, but after divorcing his wife and becoming free of all the responsibilities of marriage, he was able to resume his relationship with her without symptoms.

The gastric patient must—and generally does—find some degree of satisfaction for his dependent needs, no matter how tortuous his efforts in this direction may be. And, of course, these efforts are attempts at the solution of his basic problem. He hopes for a kind of maternalism from some significant person which will be warm, generous, unselfish and—most important—which will never become dominating, smothering, humiliating. Unfortunately, because of his trouble in accepting these needs in himself, he has trouble in recognizing such love even when it is offered. Regardless of how pure it may be, even in his own ideal terms, he will invariably look for ulterior motives. Actually, of course, such “pure” maternalism seldom exists outside the women’s magazines.

In a composite account of the gastric personality, many of

the interpersonal complexities must be blurred. For a more complete account of this basic problem the best example is probably to be found in Dostoevski's novel *The Possessed*. This is the character of a liberal intellectual who lives on the charity of a wealthy older woman with whom he has long had one of those passionate friendships popular in the 19th century. Although outwardly he appears a more dependent person than the majority of our energetic patients, and though his symptoms appear a little farther down in the gastrointestinal tract, his attacks of "summer cholera" appear without fail when ever he is made unpleasantly aware of his dependent position. When this elderly man finally summons up the courage to leave his tyrannical benefactress, he does so with a theatrical display of independence, marching off across Russia with a knapsack on his back. Characteristically enough, he falls ill almost immediately and has to be nursed by a motherly fellow-traveler—until his quarrelsome Lady Bountiful can rush to his side for a deathbed reconciliation.

At this point we can begin to inquire into the reasons for the precocity of these individuals. What were the early pressures which surrounded dependence with so much anxiety and forced them into such premature independence?

Several writers, notably Mittelman and Wolff, have described the social and economic changes of this century which have limited opportunity without sanctioning failure or dependence⁵. Since the conflict between dependence and independence is, of course, present to some degree in all of us, these socio-economic changes may perhaps account for the fast-rising incidence of gastric disorder in our culture. Obviously, we all try to "grow up" as fast as possible and early learn contempt for those who remain "babies". Yet we are not all suffering from gastric neurosis; furthermore, there are other psychosomatic disorders in which this same conflict is a crucial one. It is not yet possible to explain, without resorting to speculation about constitutional factors, why the stomach should bear the burden of the conflict in certain individuals and not others. There is enough evidence, however, to show that the

"gastric type" has had certain specific pressure, in addition to the general cultural pressures affecting us all, which have deprived him early in life and to an unusual extent of a most important condition of childhood: the privilege of being helpless, the "right"—so to speak—to be taken care of.

When J. was 5 years old, his father suffered a spinal injury in an automobile accident which left him an invalid. Until that time he had been successful enough as a clerk in the local bank, and his invalidism had a profoundly disturbing effect on the life of his family. While he had no choice in the matter, he hated the idea of his wife becoming the wage-earner for the household and he deeply resented his own supine role. Thus he vacillated between periods of passive resignation, which were in themselves a reproach, and periods of active querulousness during which nothing seemed to satisfy him. Before his accident he had been moderately concerned about J's welfare but regarded child-care primarily as his wife's province. Now he became extremely impatient with the child, particularly when it seemed to him that J. was not diligent enough in preparing himself for the responsibilities of adulthood. J's athletic achievements pleased him but he always found something about the actual performance to be improved upon. His attitude toward schoolwork was similar: J's grades were never quite good enough; he took his studies too lightly, did not work hard enough for examinations. J's difficulties under this treatment were made all the more acute for being an only child.

J. recalled that at about the time his father was injured, his mother began to have "bilious attacks", consisting of headache, vertigo, nausea and often vomiting. She was always on some special diet which the last physician had ordered; the medicine cabinet was always full of stomach remedies, patent and prescribed. She was just as solicitous of J's health as of her own, and she generally shared with him the dietary regime of the moment. In the conventional sense she "spoiled" him; at least she was indulgent wherever his material wishes were concerned. In her own way, however, she fretted over him with as much ambivalent anxiety as his father displayed. While his father worried about his not getting ahead fast enough, she worried about his getting ahead too fast—with reckless disregard of health and safety. "She'd worry if I even went out on the street

by myself." She was obviously devoted to him and often reminded him when she was unhappy that he was "her whole life". Since she regretted his going out with girls in high school, complaining that there was plenty of time for such things later, he learned to keep this part of his life hidden from her.

In a broad sense it can be said, therefore, that the father's invalidism operated early as a spur to J's precocity: when he lost his position as head of the family, J. was driven to take his place. Such an analysis, however, robs the situation of its complexity. Actually, when the father was rendered helpless he underwent a change in personality which distorted all his attitudes toward his son. Such was his reaction against his own parasitic role in the family that he was compelled to strike out at any trend in his son which at all resembled this new role of his own. It is natural, then, that dependence, defeat, helplessness, passivity should soon begin to seem as repellent to J. as to his father.

It will be recalled that his mother, on the other hand, was pushed into a more "masculine" position as breadwinner for the family—a position which we can assume was just as difficult for her to assimilate as the father's helplessness was for him. Physically she reacted with gastric symptoms. Psychologically her attitude toward her son must have undergone a change: his dependence would become more precious to her, while self-sufficiency on his part would arouse new anxieties related to her somewhat unwilling role as head of the family. At any rate, J. soon felt that his mother was smothering him with possessive maternal love and obstructing his efforts to be "grown up". To put it briefly, one parent drove him toward independence, disapproving of any sign of childishness, while the other parent urged him in a sense to remain a child, reacting with exorbitant anxiety to his desire for independence. It is hardly surprising that in later life J. found both horns of the dependence-independence dilemma too sharp for comfort.

While most gastric patients do not have such dramatic examples of invalidism in their families, their histories show,

almost without exception, this particular psychological pattern. Thirty-six, or 25% of the 146 patients, were forced into premature independence through the actual loss of one or both parents, by separation, divorce, or death. Among the others there is a striking incidence of fathers who have lost their paternal prestige in the family, through injury, disease, and social or economic catastrophe; of mothers who have been somehow unable to adopt—or have been ambivalent toward—their role as head of the family; and of sons who have in some fashion and to some extent taken on this responsibility themselves.

In the above-mentioned study there were several other statistical findings which illuminate the problem of background in the gastric neuroses³. Fifty-five, or 38% of the 146 patients in the series, had one or more severely dyspeptic parents who required years of medical attention. It could be assumed, on the basis of these figures, that there is perhaps an hereditary factor which determines dyspepsia as the "disease of choice" for these people. It could also be argued from the same figures that environment determines the choice of disease, since it must be remembered that these patients grew up in an atmosphere where special diets and stomach nostrums were the order of the day—where the whole subject of food, feeding, and being fed received constant anxious attention. What seems of more clinical importance, however, than vaguely defined constitutional or environmental factors, is the kind of personality these dyspeptic patients had, and the specific kind of relationship they carried on with their children. For many in the group their psychological status as "older" children was at least partly determined by their sibling position in the family. Fifty-two, or more than a third, were either oldest or only children. Other patients, members of large families, came to occupy the position of "older" children as the older siblings moved out of the group. Still another example of precocity, influenced by the sibling constellation, is that of the young man, neither the youngest nor the oldest of 9 siblings, but the only male. He became a rather effeminate individual, compelled to demonstrate his manhood in various strenuous

ways. In adult life he held a series of hazardous jobs, ranging from motorcycle racing to flagpole painting.

Earlier in this paper it was mentioned that no other psychosomatic disorder illustrates quite so well the complex interrelationships between psyche and soma. This observation has particular significance for the therapeutic management of gastric neurosis. So far as the stomach is concerned all treatment, psychiatric or medical, attempts to reduce the gastric hypermotility and hyperacidity, which are the physiological end-disturbances in the psychosomatic chain of events already described. The entire problem of psychotherapy in gastric neuroses cannot be dealt with here; several cases of successful treatment are reported in the psychoanalytic literature². Nor is it proposed to deal here with such medical measures as special diets, sippy regime, alkalies, anti-spasmodics, sedatives—whose usefulness and application are adequately described elsewhere—except insofar as they involve in their administration the psychological attitudes of the attending therapist. One might say, in this regard, that the attitude of the physician supplying *whatever* treatment has an ultimate physiological effect on the patient's stomach, as does the attitude of the patient towards his physician. The discussion here will be restricted to some of the intricacies of the hospital management of gastric neuroses.

The first week J. was in the hospital, he had all the usual preliminary studies. gastric analysis, G.I. series, blood count, urinalysis, stool examination. The only positive finding was a relatively high gastric acidity. The medical consultant prescribed a soft diet with supplementary milk-and-cream feedings and sippy powders.

At first J. was conspicuously cheerful and cooperative, but his manner quickly changed to one of more obvious anxiety. He admitted that life in the hospital with its numerous procedures bewildered him. He slept poorly, even with sedation. His dyspepsia, if anything, was worse: he vomited practically every meal and complained bitterly of a gnawing discomfort in his epigastrium. When his wife visited him, he quarreled with her about bringing the wrong books for him to read. With the doctors he was almost as

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irritable, although he managed to force a constrained politeness. He felt that not enough was being done for him: there must be *some* medicine which would make his stomach better. Considering the way he felt, he might as well be home.

As physicians, we have become so inured to the part hospitals play in our professional and social lives, and the prominent part we ourselves play in hospital life, that it is difficult for us to consider the complexity of hospitalization as it affects the average gastric patient, particularly those who have had no previous hospitalization. What we are apt to blanket under the term "hospital routine" may actually be for him a special sort of regimented existence with its own special terrors. Like J., most dyspeptic patients find hospitalization a new form of helplessness to contend with. Regardless of their particular status in civil life, once they are formally registered they give up their own clothes for a hospital uniform, to become one of the many in a peculiar medical world presided over by doctors and nurses, who seem to regard it as part of their duty to tell them when to sleep, when to wake up, when to bathe, when to eat. The average gastric patient has fought a lifelong battle, at great cost, to leave such an authoritarian existence behind him. Not only does the hospital machinery seem to strip him of his prestige as an individual, but it subjects him to mysterious and frightening rituals, for which his previous experience does not provide. Unfortunately, the average physician does little to resolve the mystery. Unless he goes to the trouble of explaining what is to happen *before* it happens, what is to him just a routine gastric analysis may become for the patient a new and fiendish torture. Similarly, a G. I. series may seem a very prosaic matter to him, but to the patient, unprepared for the dark room and the fluoroscope, it may assume the proportions of a nightmare. And, as in a nightmare, this terror may color all its surroundings, so that soon the most ordinary aspects of

hospital life are met with foreboding.* The patient may even sense that there is accumulating about him—on the ward and in the laboratory—a body of evidence proving a dreadful outcome to his illness; and unhappily he can always find clues in the doctor's most innocent words or expressions to confirm his worst suspicions. It would be of great advantage if each hospital ward could be assigned one person whose chief duty is talking to patients, preparing them for the exigencies of hospital life, and dealing with misinterpretations as they arise.

As J. becomes irritable, demanding, and more dyspeptic during his first few days in the hospital, we are reminded of those crises in his marriage when his activity about the household, and his solicitude over his wife's comfort, gave way to indigestion and bitterness over her failure to provide these same comforts for him. As mentioned above, many gastric patients are disturbed by the process of hospitalization, with resulting exacerbation of symptoms. The correlation between their behavior in the hospital and their behavior in previous relationships *must* be emphasized, since it clarifies one of the most important problems of therapeutic management. The physician who is unaware of either these previous difficulties, or of the vicissitudes of hospital life, is too apt to see only that a certain patient, given the usual medical treatment, has unaccountably reacted with increased symptoms. He may also note in passing that the patient seems to be a rather disagreeable person, and he may also recall that the latter was much more pleasant and cooperative the first day or so. With his vision restricted to the stomach, he will probably not perceive that this relapse—personal and gastric—is a general response to the same kind of situation which always provoked symptoms in the past. At this point, therefore, the doctor is apt to change the medication—although the fault does not at

*There are, of course, certain dyspeptic patients, familiar to every physician, who have had long experience with hospitals through their own and their parents' dyspepsia. To this group, the routine is not only unfrighting but actually pleasant; in fact, they seem to find the kind of protection in the hospital that others might find in a maternal mate. These patients are apt to relapse *after* they leave the shelter of hospital life.

the moment lie in the medication—and no modification of it is likely to answer the patient's requirements. His tolerance for the patient's demands continues to decline, in proportion as his medical procedures continue to fail. The end result of the process is usually that the doctor's therapeutic interest, not unnaturally, gives out; he regards the patient as "neurotic" or "spoiled" and turns the case over to the interne or the nurse—a "rejection" which further serves to increase the patient's helplessness in a threatening world. We might pause here to note that if the doctor had understood the reasons for the patient's decline, he need not have felt discouraged. He would have realized that, despite all his own professional skill, the fault lay in the patient's reaction to the hospital situation; and thus he himself might have remained in a better emotional position to deal with the patient's anxiety and misinterpretations.

Even under the best circumstances, a patient may become involved in a demanding relationship with the staff. This constitutes an extremely difficult problem in management, principally because it is so hard to respond to such a patient with the kind of *consistency* he requires. Some doctors or nurses feel his demands as though they were a reproach, and they try for a time to be all-bountiful parents, complying with every new request. But eventually something has to be refused, and a scene ensues. This may be over such an issue as whether he should have one or two sleeping capsules—reminiscent of the marital quarrels already described—except that in this case it is the patient who is reminded of all that has been done for him. Other doctors and nurses take a more severe attitude from the beginning with a tendency to deny any and all requests, but this total "rejection", too, seems only to intensify the patient's needs. Under such authority, even though he is unable to express his dissatisfactions verbally, his symptoms continue and usually grow worse.

It is often humanly impossible to avoid both pitfalls: the rejection following overindulgence and the rejection which is part of a too-stringent attitude. It is in this area that we, as physicians, run squarely into our own emotional bias—our in-

tolerance of dependence in patients—and are thus unable to maintain an approximately realistic attitude. It becomes imperative with demanding patients to state firmly and kindly and consistently what requests can be satisfied. If the physician can avoid a punitive attitude, he can give the patient real relief by thus circumscribing his world for him. Not knowing what the limits are is one of the factors which gives constant momentum to these demands, until they become literally insatiable.

When J. became irritable, daily psychotherapeutic sessions were arranged. At the same time all the preliminary investigations were completed, much to his relief. One of his greatest fears was allayed, in fact, when he learned that X-ray revealed no ulcer. By the beginning of his second week in the hospital he was beginning to feel much more comfortable, with corresponding diminution in his symptoms. At about the same time he discovered another patient on the ward, who had played football against his high school. The two struck up a friendship, founded largely on mutual interest in sports, which made hospital life much more companionable for him. Moreover, one of the older nurses took an interest in him, too, and let him help her with the temperature charts, which he enjoyed doing. After this, his improvement was rapid and continuous except for one brief return of symptoms, just after his boss had phoned to find out when he was returning to work. J. left the hospital at the end of his third week.

One would have a difficult time assessing the exact reasons for J's improvement, but it is evident that formal psychotherapy played only one part in the whole therapeutic process. Of unquestionable importance were two fortuitous events—his friendships with the other patient and with the maternal nurse—although the reason for this is not quite so self-evident as it may appear. When any patient becomes involved in the terrifying network of misinterpretations, arising from what he conceives as a totally hostile environment, it is of the utmost value to him to find one "reliable"—*i. e.*, obviously not hostile—figure on his landscape, preferably a figure of authority. The confidence and relaxation generated by even a single rec-

ognition of this kind are enough to change the whole landscape: the environment, which lately seemed so threatening, can now be seen in more realistic proportions. At the same time, his feeling of worth and dignity is restored by being treated on a basis of equality, rather than as a helpless "baby" or patient; so that the anxiety arising from loss of prestige, which governs his stomach, also disappears.

This, in short, is what the only form of psychotherapy possible under hospital conditions aims at: the creation of a controlled but "reliable" and friendly relationship which will allay anxiety, correct misinterpretations, and restore self-esteem. While only a thorough psychoanalysis can hope to modify the gastric patient's conflict, the psychiatrist working in cooperation with the hospital staff can maintain sufficiently favorable conditions for the patient to insure at least a remission of symptoms.

The physician thus faced with the pleasant phenomenon of remission—if not recovery—is somewhat in the position of a playwright whose drama has unaccountably made a hit. He would like very much to believe that this success is due entirely to his own skill, but honesty compels him to give at least partial credit to the director, the scenic designer, the clever actors who carried out his directions, the theater management which provided favorable conditions for his play, and—most variable and least foreseen of all—he must give credit to all the social, temporal and psychological accidents which determined the mood of that particular audience. This is not to say, however, that the playwright has no reason to congratulate himself, but only that the most skillfully constructed plays may fail through no fault of their authors; we simply do not yet understand all the factors in their production.

The parallel to be drawn from this is that the Positivist assumptions which medicine has inherited from 19th-century science make it very difficult for us to adjust our thinking to the new demands made upon us by psychosomatic medicine. We are being forced more and more into the role of collaborators in—rather than sole initiators of—treatment. And just

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as the playwright must keep in mind all the human variables of staging, acting and audience reaction, even as he plans his scenes, so must we learn to submit to a more collective, as well as a broader humanistic, approach when we try to control all the uncontrollable variants which human pathology presents.

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ANXIETY STATES AND THEIR INTRAMURAL MANAGEMENT

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We are all predisposed to the development of anxiety. We are all born infants and as such are practically impotent, able only to cry, kick, and toss about; we require aid in every respect of our existence. Very early in our lives feelings of dread, insecurity, and anxiety are developed by falling, stumbling, squeezing and burning our fingers. As youngsters we are repeatedly restrained and repressed by the superior forces of the family and society and are punished if we rebel. We are frequently frightened by individuals, by animals such as cats and dogs, and by natural phenomena such as lightning, thunder, and darkness. Thus we are very early in life made conscious of our limitations and predisposed to the development of anxiety states, particularly if unduly restrained or if subjected to traumatic experiences.

The infantile family romances known as the Oedipus and Electra situations are common sources of anxiety. The child would not be threatened with castration if it did not subconsciously cherish certain feelings and desires. When the boy sees the powerful father as his rival for the mother, when he becomes aware of his aggressive tendencies toward his father and his sexual desires toward his mother, he is quite right in being afraid, and the fear of being punished by the father may, when reenforced phylogenetically, be expressed as fear of castration.

In early infancy the organism is not equipped to cope psychically with large amounts of anxiety reaching it from without or within. During infancy and childhood it is of paramount importance that the persons upon whom the child is dependent shall not withdraw their tender care. Many adults, although they develop means of dealing with a wide range of stimuli, although they are mature enough to be able to gratify the

greater part of their needs themselves, although they know perfectly well that castration is no longer practiced as punishment, nevertheless behave as though the old danger situation still existed. They remain under the influence of the old causes of anxiety. In many instances the old causes of anxiety have in reality become inoperative, but only after having first brought neurotic reactions into existence. In not a single adult neurotic do the indications of childhood anxiety ever fail of occurrence. Certain of the danger situations survive into a later period of life by means of modifications in keeping with that later period. Thus, castration anxiety may persist in the guise of syphilophobia after it has been learned that castration is no longer customary as a punishment for giving the sexual appetite free range, but that serious disease, instead, threatens instinctual freedom.

Certain other of the things that occasion anxiety are destined not to disappear at all but to accompany the individual throughout life, such as the fear of the superego. In their response to danger many adults remain infantile, continuing to react with anxiety to situations which should have long ceased to evoke it. In the animal phobias the danger is perceived entirely as an external one. In compulsion neurosis the danger is to a large extent internalized.

The root element of anxiety is the emotion of fear; fear of bodily harm, fear of withdrawal of love, fear of punishment, fear of failure and of inadequacy, fear of not being equal to the demands that will be made upon one. A distinction between feelings of fear and anxiety cannot be sharply drawn. The indirect effects of fear and anxiety, namely mental attitudes, emotional reactions, and compulsive and substitutive acts, are more important than their direct bodily effects. People suffer more from anxiety than from what apparently provokes the anxiety. The fear of what may result from masturbation is more detrimental than the practice itself, if masturbation in prison can be construed as detrimental. Anxiety and fear of what may happen as a result of loss of sleep probably cause more mental disorders than the actual loss of

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sleep itself. Major fears and anxieties, such as those of persecution and insanity, may result from failure to overcome lesser anxieties and fears.

Anxiety may exist without any association with specific ideas. The patient may feel anxiety without knowing why, and be absolutely certain that there is no ground for it. In many cases, the anxiety itself creates the ideas to which it becomes attached and which it apparently conditions. In most cases, however, one can easily demonstrate that such ideas are secondary. The anxious patient seizes on something that might produce anxiety, such as an uncertain financial condition, an insignificant symptom of a bodily disturbance, or any mistake he may have made in the past. Even when circumstances can convince him that the ideas were wrong, the anxiety does not improve in consequence but instead attaches itself to a new idea, sometimes a phantasy.

Anxiety is commonly accompanied by physical symptoms. Headache, nervousness, insomnia, gas, heartburn, and shortness of breath are common. A heavy feeling in the chest, a feeling of pressure or of pain may be experienced. Palpitation may or may not be present. The pain may even radiate into the left arm. Patients frequently experience a pulsing in the abdomen or a flowing sensation which may rise to the head, and other peculiar feelings in the head such as a knocking, pressing, or fullness.

Lack of knowledge regarding prison life may cause many inmates of penal institutions unnecessary anxiety, for many believe they are sent to prison to be punished and not as punishment. Many come to prison with the feeling that the experience must affect them adversely and are anxious primarily on that account. This predisposes them to preoccupation with their state of health. Thus the sick line in prison is swelled by many who were not hypochondriacs in civil life. These men are unduly concerned about their state of health and focus their attention upon trivial ailments which grow thereby in intensity.

Anxious depressed states are commonly precipitated by

guilt and the accompanying shame, and by incarceration with its resultant sense of failure. Guilt reactions are more commonly seen in first offenders, and reactions of failure in those who have been previously incarcerated. The sense of failure is the negation of the striving for superiority, which is probably just as prevalent among prisoners as among men in the free world.

Anxiety states occur probably ten times as frequently among inmates of penal institutions as among civilians. Many inmates with predisposition to mental disorder, upon being sent to prison, react unfavorably. This applies even to the recidivist, who would be expected to feel less keenly the painful loss of freedom. The emotional shock and depression which accompany the loss of freedom, and the separation from loved ones and friends, predispose the prisoner to self-preoccupation and to persistent introspection, making him feel much more keenly guilt and apprehension for the future. These, in turn, predispose to the development of anxiety states and mental disorders. This is especially true in the case of first offenders, and of accidental offenders who often still possess considerable self-respect and honor.

Immediately after confinement, psychic tension commonly sets in. In extreme cases the prisoner becomes silent and lost in brooding. He observes little that goes on about him and remains motionless in one spot. His face takes on an astonished expression; the gaze is vacant and indefinite. Movements may be hesitant and uncertain, like those of a drunken man. Severe anxiety overpowers the inmate and crowds out all other concepts and sensations, dominating the entire personality. Consciousness becomes more and more clouded. Illusions, hallucinations, and delusions may appear. At the same time, the inmate complains about all sorts of bodily sensations. Severe motor excitement may set in. The inmate may become noisy, scream, run aimlessly about, and destroy everything in his way. With this, the anxiety state has reached its height. At this stage, consciousness is often entirely in abeyance, and the episode is followed by complete amnesia.

Some patients exhibit an apparent total blocking of all

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thought processes. They are ignorant of the most commonplace facts, and sometimes forget such elementary things as their own name, age, and place of birth. Many show a marked tendency to elaborate all sorts of false reminiscences about their past life. Recovery is often dramatic. The patient may come to as if from a dream and evidence a more or less complete amnesia for what has transpired.

The anxiety state may be manifested by a condition of apathy with inability to concentrate and difficulty in thinking, accompanied by nervousness, insomnia, and other nervous manifestations. The anxiety may increase to maniacal outbursts, or there may be increasing apathy with mutism and refusal of food. Some show childish speech and behavior. Apathy and stupor are sometimes preceded by convulsions. These may occur in individuals without any epileptic history. Although recovery may take place suddenly, it is usually more gradual. The condition may last for days or for months. A sub-conscious wish to be considered sick and thereby to be removed from prison and thus relieved of having to work and to adjust to inmates and officers frequently bars any favorable response to medical treatment.

Anxiety states and associated mental disorders occurring among inmates of penal institutions differ from the mental disorders of civilians in several ways. They develop in relation to situations associated with imprisonment. The entire symptom complex commonly disappears dramatically upon change of environment. Often we note the absence of the previous symptomatology upon removal from prison and arrival at the prison hospital. This may be associated with a sub-conscious wish in some to be considered insane and thereby to avoid, in a way, the sentence meted out by the court. There are many situations to which an individual in prison reacts with symptoms of anxiety, particularly if the individual is emotionally immature or neurotic. Many men, both in and out of prison, remain infantile in their response to unpleasant, dangerous, or threatening situations. There exists, too, for every person, a maximum mental load which he can carry, and be-

yond which anxiety and symptoms of mental disease appear.

The separation of the inmate from family, loved ones, friends, and people with whom he would ordinarily associate, and the removal of emotional outlets, predispose to the development of anxiety states. Frequently such states are precipitated by the slackening of mail from home, with loss of interest in the prisoner's cause and the withdrawal, to varying degrees, of love and emotional support. In this group should be included reactions to divorce by spouse and concealed or open rejection by parents or siblings. Neurotic and emotionally immature individuals frequently react violently to estrangement from loved ones or even to withdrawal of love. The form this takes depends to a considerable degree upon the early life experiences of the individual.

Anxiety states sometimes develop during the interval inmates are awaiting response from various petitions for amelioration of sentence, such as application for executive clemency, pardon, parole, petitions for writ of habeas corpus, application for restoration of forfeited good-time, application for restoration to duty in one of the Armed Forces, and petition for changing or setting aside of sentence while the term of court is still open. Such states are also frequently precipitated by homosexual conflicts. Individuals sexually fixated at immature stages of development, or homosexually predisposed, often develop anxiety and panic states as the result of violent struggles within themselves regarding homosexual activities and fears of succumbing to homosexual impulses against the dictates of the superego. Occasionally the anxiety state is precipitated not so much by intra-psychic conflict over homosexual impulses as by fear of apprehension and punishment.

A smaller group is composed of those inmates who have fallen out of grace with the general inmate body. To this group belong inmates who have not lived up to the code, either by betraying the trust of other inmates or by reporting to officials the misdemeanors of their fellows, inmates with a compulsion to steal even from their cell mates, psychopaths who have spread malicious stories about fellow inmates, and

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the gambler who has found it impossible to pay off following some unexpected reverse.

Anxiety states are frequently encountered in individuals who have detainers pending against them and who are wanted for trial or servitude on charges other than the one for which they are incarcerated.

Another large group is to be found in the pre-release anxiety states. Here are many individuals who were denied attention, interest, and affection as infants and children, and who have grown up with a strong component of insecurity and inadequacy in their personalities. These individuals recoil from competition, even in prison. Many feel more secure in prison than in their own communities. While incarcerated they feel that their responsibilities have been taken away from them and not given up. Many have been previously incarcerated, have defective moral and ethical sense, and have lost the feeling of stigmatization commonly occasioned by being in prison. The condition usually begins several months prior to the release date, with progressive increase in anxiety until discharge. These individuals frequently do not feel equal to the demands that will be made upon them on release. In many there is a sub-conscious desire to remain in prison and so to avoid the cold, cruel world. They consciously, but more often unconsciously, commit anti-social acts which return them to prison, in order to obtain the relative security of the institution where most wants are provided. Prison is frequently welcome to individuals with little heterosexual drive, strongly narcissistic personalities, and homosexuals. Individuals of the latter group may purposefully commit offenses which will return them to prison and to the company of a homosexual partner.

The treatment of anxiety states in prison is best accomplished by individual psychotherapy. Short and superficial therapy is frequently of considerable value. Such therapy is often the only therapy that can be given because of the time factor. Many cases, however, are in need of a deeper analytic type of therapy. Group psychotherapy probably has much to offer in the treatment of intramural anxiety states. Many of

the simpler anxiety states respond favorably to reassurance in the hospital setting. Anxiety attacks occurring in depressions with marked tension are the most difficult to treat. Careful physical examination, accompanied by X-ray and laboratory studies, with an explanation to the patient as to how his condition arose (frequently as a reaction to uneasiness, worry, and anticipation), is often successful in the treatment of the less complicated anxiety states. Many intramural anxiety states are precipitated by the inmate crossing his bridges before he gets to them. By educating the patient to tackle problems only as they arise, much can be accomplished. Such education will often guard against recurrence of anxiety attacks. Inmates serving long sentences commonly meditate and brood over the years they will have to remain in prison, and over the mistakes they have made in the past. If these inmates can be educated to chalk yesterday up as experience, to live today, and to tackle tomorrow's problems tomorrow, a great step forward has been made toward recovery from the anxiety state.

The families of inmates hospitalized for the treatment of anxiety states should be advised as to the inmate's condition. They should be encouraged to write frequent cheerful letters and, if possible, to visit the anxious inmate. The recovery is in many instances dramatic, following the receipt of a cheerful, encouraging, loving letter from home, spouse, parent, sibling, or friend. Focusing his attention upon the possibility of early release upon parole sometimes helps the patient with the short sentence to overcome his anxiety. Such encouragement is indicated only in cases where the likelihood of the inmate being paroled is fairly good. After recovery, however, an attempt should be made to leave the inmate more realistic and practical-minded. He should be advised that, although it is to his interest to look forward to and aim for parole, in actuality not many inmates are paroled; that all decisions are made by the Parole Board; that there are many factors to be taken into consideration; and that no one except a member of the Parole Board can usually advise him as to his chances for parole. This

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is indicated so that if the inmate is denied parole by the Board the resulting emotional letdown will not be too great.

Many of these patients do well upon the ward, and progress favorably if placed in rooms with other patients in good spirits who are on the road to recovery. It is often of great help for the psychiatrist to enlist the assistance of the anxious inmate's roommate in getting the patient's mind off his pet preoccupations and so diverting his thinking and interests. It is well to suggest to the roommate that he do what he can to "cheer up" the patient. Inmates of penal institutions feel a strong common bond and are, not infrequently, more receptive to psychotherapeutic advice meted out by way of another inmate than such advice given directly. It is sometimes beneficial to point out to the anxious patient who is serving a comparatively short sentence that there are other inmates serving very much longer sentences, and even carrying a heavier load, who through mental discipline and correct thinking are bearing up admirably.

Where guilt feelings are marked it may be advisable to allow the patient temporarily to project some of the guilt. One must not, however, assist the patient in absolving himself of too great a portion of his feelings of guilt, as such handling may result in the precipitation of feelings of self-pity with depressive reactions. Guilt feelings can sometimes be lessened by enlisting the assistance of the Chaplain, with the encouragement of confession and prayer. This approach is of considerable value in patients with strongly religious backgrounds. Some patients are responsive to encouragement and a demonstration of sympathetic understanding from their institutional parole officer. The lessening of the guilt aids the patient in regaining, to varying degrees, his personal self-respect and honor. The sense of failure that frequently accompanies guilt may be to some extent alleviated by pointing out to the patient his accomplishments prior to his incarceration, and the knowledge and experience he may have gained during his incarceration, through classroom courses, correspondence courses, and trade training.

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Where there is much apprehension for the future and the patient is soon to be released, it is advisable that the psychiatrist do what he can to diminish this apprehension. This apprehension is usually accompanied by feelings of inadequacy and insecurity, and feelings that one will not be able to come up to what is expected of him. There is frequently estrangement to varying degrees from loved ones. Many of these patients recover following the improvement of family relationships. A letter through the Chief Parole Officer and Warden to the patient's people, setting forth his condition and the necessity for their support—moral rather than material—as necessary for his recovery and ultimate rehabilitation, accomplishes more than many long hours of psychotherapy.

Anxiety states precipitated by homosexual conflicts are best treated by isolation of the patient in a private room for several days, followed by supervised contact and association with other patients in the day-room and on the hospital recreation yard. This assists in building up some degree of self-confidence and the ability to handle homosexual urges. It is mandatory, however, that the environment not be stimulating. The aggressive homosexual must be shielded from even the sight of the invert with light beard and feminine swagger and mannerisms.

Many of the patients hospitalized upon the psychiatric ward for the treatment of anxiety states are looked upon by other Medical Officers and by Custodial Officers as being "gold brickers", or malingerers, and to some extent this is correct in that frequently emotionally immature, unstable, and neurotic inmates let themselves go and have acute anxiety attacks. These may be consciously or sub-consciously reinforced by a desire to escape from the monotony, trials, and tribulations of life in the regular prison body. Inmates with anxiety states coming to the psychiatric ward from Punitive Isolation or Segregation, where the state has been precipitated by confinement with little or no privileges, have meagre psychological incentive to get well. After having enjoyed the privileges of listening to the radio, playing ball and other games in the yard, and sun-bathing several hours daily during the summer months,

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many patients cannot reconcile themselves to returning to their original status. They progress slowly and favorably until the time of scheduled discharge. Repeated attempts to shake them loose at the contemplated time frequently fail. A fair percentage, however, do accept modified programs after the psychiatrist has interceded in their behalf. Assignment to interesting work in quiet surroundings under an understanding supervisor, restriction of contacts with other inmates, and quarters in a one- or two-man cell accompanied by some lessening of restrictions are often of value.

TREATMENT OF TRAFFIC OFFENDERS

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Probably the most serious criminological problem that exists in this country is the problem of the control of automobile drivers. In some communities as many as one-fourth of the population drives fairly continuously, and a variable fifteen percent in each large city comes in conflict with the law during a three-year period. Because most of the violations are mild misdemeanors, having to do primarily with parking or driving some place where the operator shouldn't (but without endangering life and limb), and because so many of the offenses seem to be inadvertent, the legal tendency at the present time is to consider the traffic violator as a non-criminal person. Yet the traffic violator is a serious offender against the common weal.

In the average year during the late Nineteen-Thirties, more people were killed and injured by automobiles than were killed and wounded in all of the wars of the nation up to that time. In the United States, forty thousand people were killed each year, and as many as one million and a half injured. Any type of misbehavior, error in judgment, or lack of capacity to behave properly which results in this damage to mankind—without regard to the property loss appertaining thereonto—is a serious problem. Homicide due to motor vehicle accidents should be considered as serious as other types of crime, even though it lacks the dramatic nature of murder and is considered by unthinking people to be "likely to happen to almost anyone". An automobile accident can be premeditated. Detective stories and an occasional unverified newspaper account indicate that persons have been run over deliberately. If this be the case, the chances are that the murderer by automobile is an abnormal person. Most accidents are due to human failure, and in the large number of instances the human failure con-

sists in either not knowing the traffic laws or ignoring them. In most states an opportunity is given to the potential vehicle operator to learn how to operate his car and to know the nature of traffic laws. Even if he were not given brochures or other instructions, an alert individual would learn the traffic laws in a relatively short time by riding with persons who already know and obey them.

The motivation for the non-accident violation may be a little bit more obscure. Usually some psychiatric trait of the violator is responsible for the offense. This trait may be egocentricity, in which he is indulging because of the fact that he was suppressed as a child and it was only as an adult and the owner of an automobile that he could express his personality. In other cases, drivers become too aggressive to compensate for an unsatisfactory home environment, love life, or economic adjustment. In other instances, the traffic violator is inclined to consider the traffic laws as less important than other laws of conduct, partially due to the bad example set by the majority of other drivers, and partially due to the fact that there are so many traffic laws and they vary so much from time to time that they lack sufficient coherence to become a part of his personality.

In general, traffic law violators commit their offenses because of: (a) faulty driving habits, (b) ignorance of the traffic laws, (c) poor physical condition, (d) inferior intelligence, (e) mental disease, (f) psychopathic personality, (g) bad driving attitudes acquired through improper training or because of personality deviation, and (h) chronic alcoholism.

The therapy for these various causes naturally either fits the cause or offers some palliation for the condition which exists currently, and the treatment can be divided into two classes: (1) prophylactic, and (2) direct therapy.

Prophylaxis. Usually prophylatic treatment must be given before the person begins to drive. The indoctrination of the child in public and private secondary schools, even before he is old enough to operate a motor vehicle himself, serves a very useful purpose. It makes him alert as a pedestrian and also

makes him show considerable interest in the driving of older persons when he is riding in a motor car. The child is an excellent therapist for his parents' bad driving, when he asks his father why he goes through a red light and makes other artless comments which the parents dare not resent. In addition, some high schools provide an actual course in training the child to be a driver. He (or she) is indoctrinated into the driving laws and knows them well before actual driving is permitted. After the laws become almost a part of the personality, the driver's instruction deals with the mechanism of the motor car. The child learns, for instance, how fast a car can be accelerated safely and why it is necessary to shift to a lower gear in crossing a track (to prevent stalling on the track). He learns such things as safe stopping distance, the danger of "over driving" headlights, and comes to have a feeling for the mechanical capacity of the motor vehicle. If the training program is well arranged, the potential driver learns to operate his motor car over a prescribed course which offers all the variations which he would actually have to face in traffic. Drivers having a tendency to express their immature personality are controlled by the teacher, and are warned by example and repetition of the danger in violating traffic laws.

The second phase of prevention is the elimination of physically and mentally unsound drivers through the careful application of driver's examinations. Such examinations, if properly given — and they are not at the time of writing — should include a competent physical examination by a disinterested examiner, since the family physician should be expected to be sympathetic with his patient rather than society. Neurological disturbances (*i. e.*, disturbances of coordination, of the eye, or of the limbs) are more important than physical disease of the body proper.

The presence of physical disease must be evaluated in terms of the driver's attitude and his ability to compensate intellectually and emotionally for the physical disorder. If he compensates aggressively, he will be a dangerous driver, where-

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as if he exercises more caution because he knows he has the physical ailment or physical sickness, he may be an even safer driver than many physically sound drivers. Special considerations are noted as follows:

(a) At the present time the epileptic and narcoleptic, the very feeble-minded, the grossly antisocial, those suffering from frequent migraine attacks, and those with severe psychiatric ailments, must not be granted a license.

(b) The licensing examination should also include a thorough investigation of the person's knowledge of traffic laws. This knowledge should not be verbal alone, but should demonstrate his ability to recognize a violation when he sees it, and to meet any emergency situation without violating the law himself.

(c) A road test seems advisable, although such a test to be valid must be over a controlled area and must be given by the same examiner (or those trained and controlled by one man), and be in an area where much traffic friction is present in order to test the potential abilities and capacity to meet emergencies.

(d) Traffic violations and accidents are prevented by the exercise of social controls, for most potentially dangerous drivers are convinced by the attitude of others, newspaper articles, and other sources of information that, if they have certain ailments, if they are growing old and somewhat slow in their movements, or their vision is not acute, they should voluntarily restrict their driving.

In addition, the commitment of the insane removes the majority of insane drivers from the highways before they get in trouble, and it is the same way with grossly antisocial persons who are sent for a maximum period to a corrective institution, for this, too, eliminates them as driving hazards.

It is not the practice to commit the chronic traffic offender and the chronic dangerous driver to a corrective institution for a long period of time, as is done with the more predatory offenders. If they do not drive, the majority of dangerous drivers are as well able to take care of their families economically

as the average citizen, except for the person whose occupation involves actual driving, in which case he would have to have a person to drive him or get other transportation to his place of business. There is no one who actually needs to drive in order to make economic and social adjustment.

Direct Therapy. Direct therapy runs the gamut of the treatment procedures available to a Court Clinic. In addition to this, there is also a possibility of long-time incarceration for antisocial drivers. As a rule, however, the sentences handed down for traffic offenses are not lengthy enough to have the salutary effect of the long sentences which last a number of years and keep the criminal away from society until he is somewhat chastened. The following Clinic treatments are available:

(1) Psychiatric advice, consultation, and treatment by the Clinic psychiatrist or a private psychiatrist employed by the offender. The latter case is preferable in most instances. This treatment is useful, particularly in psychoneurotic individuals and those who have severe problems of a domestic or personal nature, preoccupation with which interferes with successful driving.

(2) Court supervision, which, in the case of traffic offenders, has a chastening effect for a period of time. It makes the offender feel that he has done something which indicates a bad attitude in driving, and this feeling enters into his subconscious to an extent that it controls his antisocial, impulsive behavior. In the majority of instances, drivers have been supervised because it was the treatment of choice for mildly aggressive persons.

(3) Exhortatory treatment can be done in the nature of advice, guidance, or lectures from the bench either in chambers or in open court. The egocentric individual responds better to therapy in open court, while the schizoid person needs to be handled with kid gloves. The clinic examiner at the Traffic Court may also urge the driver to control himself and to do what he can to change his bad habits, but this is only of value

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when the diagnostic implications indicate it, for a negative reaction may arise in egocentric or other aggressive cases.

(4) Bad driving habits are corrected by lectures, training posters, and driving in company with an experienced teacher. Ignorance of traffic laws, as a frequent cause of accidents, requires that copies of the traffic laws be made available in a simple form which the not-too-high-grade individual can comprehend. Lectures by police departments, licensing agencies, appeal boards, and courts have proved valuable. In these instances, it must be remembered that in the treatment of those ignorant of the traffic laws mere verbal knowledge does not mean an ability to go out and apply those rules.

(5) Problem cases must be evaluated on their merits.

(a) Cases of inferior intelligence may be permitted to drive if they have proved in the past to have been able to drive without accident. As a rule, the defective who gets in trouble can, of course, be treated by having his license revoked.

(b) Those who have poor physical condition may be treated by their physicians. If they are crippled, it is possible to make devices which will enable them to compensate for their defects of movement and still be safe drivers. If there is danger of death or fainting, the only possible handling of the case would be to remove that person from the highway.

(c) The presence of mentally diseased drivers is a definite signal for the initiation of commitment procedures, usually by the family or a law enforcement agency.

(d) The psychopathic personality requires direct psychiatric treatment for his mental defect.

(e) The person who has a bad attitude toward driving probably needs psychiatric care. He needs to have some attention from the Bench or Clinic. It must be made clear to him why his attitude is wrong, and if possible he should be made to see into how he developed

these attitudes. Many psychopathic individuals are precluded from developing insight into their bad driving habits, and it is only reasonable to eliminate them from the driving public. One has to be extremely careful in the case of psychopathic personalities. If training is attempted by one who is very close to him, he may develop defensive reactions that prevent that person from ever being a teacher, so far as training is concerned.

Individual cases require individual treatment, but the problem cases should be treated and diagnosed in traffic courts much as they are in a hospital, so that treatment may be as specific as possible to eliminate the dangerous aspects of the driver's personality.

PSYCHIATRIC ORIENTATION OF THE ALCOHOLIC CRIMINAL

ROBERT V. SELIGER, M.D. AND VICTORIA CRANFORD

Does alcohol *inhibit* or *release* aggressive drives and damaging activities against society that result in criminotic behavior? This problem has been studied and discussed intensively by many investigators, but the evidence to date is insufficient for the conclusions to be clear cut or definite. In general, it has been our experience that criminal offenses against society are committed by individuals with poorly integrated personalities, emotional instability, conflicts with the environment and frustration; these are also found in many alcoholics whose drinking is symptomatic of their inability to adjust themselves realistically to the environment and its demands upon them.

One factor is clear, however; alcohol, pharmacologically, acts as a depressant on the nervous system, resulting in relaxation (to varying degrees and extents) of judgment and control so that underlying forces—the personality dynamics—find a more direct mode of expression. While such underlying forces may be of a passive, laissez-faire nature as well as an aggressive, disruptive one, the general result of the loosening of conscious control is the release of id urgings, in themselves amoral in tenor. Both practically and theoretically the response of the individual to alcohol is the response of the total personality, comprising the emotional maturity level and intellectual and physical endowment-equipment, functioning in a specific environment and stimulated by specific environmental situations that activate internal reaction behavior patterns. This applies just as pertinently to the non-criminal as the criminal alcoholic, but in contrast to the social drinker, the effects of even slight loss of control is a hazard

to the criminal (prison inmate, the parolee, or the released convict).

The individual who has a criminal record, if he faces reality, one of the prime objectives of modern penology, recognizes that "rightly or wrongly" society has judged, not interpreted, his behavior. Society rarely accepts legal justice, trial, incarceration and release at the end of the sentence as completely cancelling the initial provocation and crime. It would be most unrealistic to expect such an attitude. Moreover, and as unrealistically, the criminal rarely seeks any deeper solution to his behavior, past and future, than that imposed by the prison sentence and thus, on release, frequently becomes recidivistic. Objectively, both society and the criminal are at fault in this shallow understanding of, and ostrich like attitude to, psychological factors involved in their mutual conflict. Because the results of the conflict affect the individual more painfully, one of the objectives of scientific minded and enlightened prison personnel should be a more than superficial insight into his difficulties with the end result that the criminal will develop a better understanding of the motivations that led to the commission of his unlawful acts and come to the blunt realization that he must, in the future, expect more of himself than of others, and not feel that the world is to blame if he does not do his full part and more.

Modern students of criminology, in their stress on the part that society plays in crime causation, would seem to be on the wrong track as far as the rehabilitation of the individual criminal is concerned. No matter how right or wrong society is, the delinquent must recognize that the majority of people do not commit crimes and that his criminal behavior is definitely indicative of underlying personality difficulties, characterized in part by an immature approach to life. The prisoner must be made to accept the fact that fundamentally it is his personality mal-integration and attitudes that need correction, so long as he inwardly feels persecuted and belligerent, so long will his conduct continue to bring him into open conflict with the laws of society. The basic situation remains the job of

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becoming a respected and self-respecting individual, and this can only be done by the active cooperation of the individual. When he realizes that the job can be done and is worth doing then he has traveled the most difficult part of the road to rehabilitation.

The prisoner, and those working with him, must be aware of and accept these facts if he is to succeed in reintegrating himself with the community. He must understand that he will be on probation for a considerable period of time; that his actions will be closely scrutinized; that society will rebuff him, and in some instances be frankly unjust, primarily because society still fears that he may regress to criminal actions.

The individual who has engaged in criminal behavior must, as a consequence, be prepared to meet with hostility and be taught how to meet this situation without becoming embittered and relapsing into earlier patterns of defense aggression. He must become emotionally mature, or more mature than he was. If he fails to accept this, or if in a childish reaction of unthinking rage he strikes back at real or imagined provocation, it is he who will suffer.

So far as drinking is concerned, the prisoner should understand the far reaching effects of alcohol. If he drank before incarceration, if drinking was in any way associated with the planning or perpetration of his criminal acts, he should never drink again. Old habits of habitual reaction die hard, and under the influence of alcohol previous aggressive asocial forces may find easy expression. Once he makes a misstep under the influence of liquor, even if his conscious intentions were of the best, he finds himself back where he started from and burdened with intensified feelings of failure and self destructive emotions.

Drinking at any time, even for the social, controlled drinker who can stop at will, always leads to a temporary relaxation of judgment, discretion, and control. We do not need scientific research to acquaint us with this fact. Alcohol, as stated, acts as a depressant on the nervous system: the quantitative and qualitative results depend on factors that vary be

tween individuals and in the same individual at different times due to fatigue, sugar metabolism, and psychological state including mood, thought, and specific stimuli. Physiological changes of functioning include poorer coordination of thought and muscular action; diminished sharpness of sensory perception; and delayed and weaker motor performance with accompanying increase of error. Disregarding individual personality dynamics of alcoholism as a psychiatric illness symptom, the physical effects of alcohol are not conducive to controlled behavior, nor are its effects in any way predictable.

Alcoholism as a psychiatric abnormality is symptomatic of an underlying personality illness or disorder and must be treated as a psychiatric problem. That the alcoholic does not stop drinking in spite of painful experiences which include loss of job and prestige, physical torment, and other related miseries, should be adequate evidence that underlying factors are literally driving him to drink and that he is psychiatrically ill. No emotionally healthy individual deliberately does that which causes him to suffer provided that he is aware that suffering will result from such behavior. The alcoholic is, therefore, either unaware, not sufficiently aware, or does not want to be aware of the serious harmful consequences of his drinking to do anything constructive about his addiction. The reasons for this lack of insight are to be found in the unconscious and may be associated with such defined psychiatric groups as the feeble-minded, the organic, the psychopath, the psychotic and the neurotic. Physiological factors involved include cell changes and lowered resistance to the drug.

Alcoholism, uncontrolled drinking, leads to the following reaction types: acute pathological intoxication with stupor, excitement or convulsions; acute and chronic alcoholic hallucinosis; delirium tremens; marked paranoid development; Korsakow's psychosis; mental deterioration. There may also be encephalopathies (brain lesions and organic changes) and neuropathies, including polyneuritic features and, with the above

named reaction types, associated avitaminotic conditions resulting from inadequate nourishment while drinking.

In general, alcoholics may be classified into the following distinct groups: (1) Those who because of constitutional inadequacies (genogenic) are unable to meet life responsibilities and in addition to their drinking habits have other poor life habits. These individuals may eventually become deteriorated or asocial, requiring permanent mental hospitalization. (2) Those who are not too strongly endowed intellectually and emotionally and who suffer psychic frustration with underlying psychiatric disorders (manic depressive swings, schizophrenic reactions) which cause them to seek escape from life reality by means of alcohol. (3) Those who drink to flee from unpleasant life situations they cannot or do not wish to face and meet—the neurotic or psychogenic personality. (4) Those who drink to relieve various combinations of feelings of inadequacy, self-consciousness, sexual maladjustment, etc. (5) Those who drink to narcotize physical or psychic pain. (6) Those who as a result of habit plus time, body changes, and added strains and griefs of life develop from social drinkers into alcoholics.

The dynamics of personality motivation which may be found in any of these groups are summarized as self pampering tendencies illustrated by a refusal to tolerate at all any unpleasant state of mind; a drive for self expression without the resolve to take the practical steps to attain it; a more than usual craving for excitement and pleasure of the senses; a habit of sidestepping duties and obligations leading to the substitution of the rosy anesthesia of alcoholic daydreams; a definite insistent need for the feeling of self confidence, self importance, calm and poise that some temporarily obtain from alcohol.

It is also the conviction of the authors that alcoholism is evidence of latent or overt homosexuality as medically defined, or of self destructive tendencies and deep lying anxieties, hostilities, and tensions stretching far back to infantile formation.

of attitudes, sentiments, and interpersonal relationships in which identification and imitation play a decisive role. Contrary to popular opinion, science has no proof that alcoholism is hereditary, although some individuals with an alcoholic ancestry may have lowered resistance or be more sensitive to alcohol. Social inheritance involving the identification and imitation mechanisms would seem to be the basic factors, not heredity as such.

Narcotization of anxiety is a major factor in the misuse of alcohol. In some cases this anxiety is the result of traumatic experiences in early childhood which the personality was unable to assimilate, while in others it may be due to unresolvable conflicts. Other types of personality makeups that seem to require the narcotization escape device include the tense, perfectionistic, worrisome individual; the individual who has a vague inner restlessness and feels himself to be a bystander not a participant in life; the emotionally immature individual, and the individual who is consistently inconsistent, whose main characteristic is that of unreliability—the total or partial psychopath.

Individual alcoholic therapy should begin, therefore, with a careful examination to determine the "type" of drinker, the personality makeup, and the presence or absence of serious psychiatric or neurologic reactions in order to determine whether the patient should be placed in a mental hospital, a health farm, or treated by regular office visits. The acutely intoxicated individual should, obviously, be placed in a mental hospital until the toxic condition has subsided and the patient has become accessible to psychiatric examination. Psychiatric therapy consists of five separate but interrelated steps: examination and diagnosis; placement (hospital, farm, office); medical and psychiatric treatment; reeducation; continuous lifelong followup.

With all except the acutely intoxicated patient the usual psychiatric procedure is employed, including complete life history, neurological and mental status survey, and personality and intelligence tests. It is well to obtain objective data from

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a friend or relative of the patient to provide factual information about the nature and extent of the drinking and the resultant behavior changes. Personality and intelligence tests are of definite value in diagnosis and personality evaluation especially when individuals are unaccompanied and no objective data can be immediately ascertained. Of these tests the Rorschach Examination is the most useful and reliable in making a differential diagnosis, gauging the level and quality of emotional maturity, and in profile sketching the personality makeup of the individual.

Therapy and reeducation of the alcoholic patient, regardless of his place of treatment, is conducted along the following lines: Regular visits or interviews in which distributive analysis and synthesis allows the patient to ventilate and learn how to objectify his underlying stresses and tensions, interpersonal relationships and attitudes, goals and strivings; while at the same time following a regular daily routine (self-imposed or controlled by the environment) and, through discussion and observation developing new insight, views, and values. In this respect the benefits of socializing in the farm or hospital group are very important suggestive factors.

The goal of treatment is total permanent abstinence and therapy is organized to achieve this by reeducating the individual, helping him to establish new habits of living, thinking, action, and reaction to excitement, disappointment, or out and out frustration. The nature of his drinking problem is explained to him and discussed by using specific examples chosen from his own life history and including dream material, present conflicts, etc. Simultaneously, certain fundamental psychological facts are reviewed to help the patient acquire enough knowledge to help himself.

Every patient presents an individual problem and the treatment varies accordingly. One of the greatest factors in successful rehabilitation of the alcoholic lies in the interpersonal relations of the patient and the physician, with general principles subordinated to the individual needs of the patient. Other necessary factors are the careful selection of voluntary

patients with undamaged nervous systems; the personality of the therapist who should be kind but firm; time; suggestive influences and full cooperation of friends and family; lifelong follow-up. It must again be stressed that the alcoholic is a sick person and that his addiction and its causes extend over a long period of time. Thus his cure must be thought of as similar to the healing of tuberculosis scars, dependant on his keeping in good mental and physical health. It is sound, practical, common sense for the ex-T. B. patient periodically to check with his physician, and it is just as sound for the ex-alcoholic to do likewise. The crucial part of the treatment is to help the individual to reach a level of emotional maturity which will enable him to live a relatively efficient, productive, and contented life with kindly, tolerant, interpersonal relations, and an inner poise and stability.

Sociological factors play a definite part in the production of the anxieties, hostilities, and frustrations which apparently produce a need in some individuals for the narcotizing effects of alcohol. America has never been known as a nation of tee-totallers and alcoholism is certainly not unique in our time. Records, dating back to early colonial times show that many people were even then seriously alarmed by the alcohol problem which they felt was directly connected with mental illness and crime. By the early part of the nineteenth century alcoholism had come to be recognized as a serious moral and cultural problem and gave rise to a temperance movement, for a long while overshadowed by the problem of slavery, but bursting into full bloom after the war between the states.

England, to name but one country, during the 18th Century had an almost universal problem of alcoholism of the worst sort due to economic pressures of the industrial revolution, resulting in widespread pauperism, rapid urbanization, and cruel economic inequality. We should not blind ourselves with the thought that mankind has always suffered in various ways and that nothing under the sun is new. America was not settled by the ruminative inaction of the alcoholic, rather was it settled *in spite* of the near universal drunkenness of the Front-

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iersman. The distillery and the saloon were the invariable accompaniments of the frontier settler (*Cf.* the Whiskey Rebellion) and they in turn called forth their inevitable accompaniment of the revival meeting and the temperance pledge.

Within the last quarter century the trend toward the more moderate use of alcohol has been definitely reversed and there is a marked increase of alcoholism in all groups and ages. Some statistical surveys set the figures currently at 600,000 chronic alcoholics (this does not include those who have not been admitted to hospitals), 2,000,000 heavy drinkers, and about 38,000,000 social drinkers. Excluding the non-scientific experiment of Prohibition which blossomed from the work of various sincere and well-intentioned groups, we have never until recently made any organized attempt to attack this problem on a medical or coordinated basis, in spite of the thousands of arrests, admissions to city psychopathic and state mental hospitals, of accidents due to alcoholism, and the testimony of social workers and reformers as to the damage to life, health, and property due to alcoholism.

In England, where social problems were attacked publicly for many years, Fleming reported in 1937 an eighty per cent decrease in arrests for alcoholism over a 25 year period due, he felt, to:

1. Social Legislation.
2. Labor receiving equal rights and equal responsibilities with capital and management.
3. Legislated restricted hours of sale of alcoholic beverages.
4. More diversion on an active participating level of the white collar and working groups.
5. Temperance societies, active social service work with the individual and the family unit.

While Fleming's reasons are a patent oversimplification of an England ruled by the Tory party, racked by the great depression, housed in horrible slums and honeycombed with slowly dying blighted areas, it is interesting to contrast his analysis with the present American scene:

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1. Large mobile population groups with little family cohesion, tradition of residence, or homogeneity.
2. No marked social legislation until recently; no marked public disapproval of drunkenness.
3. Labor receiving "equal rights" but, as yet, *not equal responsibilities* and little or no political representation.
4. No restricted hours of sale of alcoholic beverages except in some states.
5. Fewer socially utilized opportunities for diversion or creative recreation.
6. Due to Prohibition, temperance societies are held either in contempt, ridicule, or fear, while our social service groups have, for the most part, limited their work to curative measures with acute alcohol problems.

Several states have now set up commissions to study and deal with the alcohol problem, and we feel the results reported in England, Scandinavia and Switzerland should be considered in the overall approach. Mental illness, juvenile delinquency and criminality are, like alcoholism, partly derived from environmental situations, and also, like alcoholism, they are on the increase. We are not likely to see any decrease of the social tensions within the next few years. We are entering an era which will probably be more chaotic, disruptive, and emotionally disturbing than we have ever known. Violent changes and dreadful physical and emotional conditions throughout the world will have to affect us in many ways.

Retrospectively we understand the effects of our national expansion, restlessness, heterogeneity, industrialism and historical growth on the incidence of alcoholism to be enormous, due to mass and individual insecurity and to change in nearly all spheres of life plus quantity and quality of mobile living. Preventive measures on a broad basis should definitely, therefore, incorporate ways and means of helping to modify or change our social environment so that it will not tend to stimulate the production of anxiety and tension but rather will tend to provide relative security and support through healthy com-

munity living. Opportunities for such now exist in the media of PTA groups, adult education centers, civic organizations, etc., but the general public is either uninformed or does not utilize these to the fullest extent. It is up to the leaders in all fields to act more vigorously to help bring a deeper participation and interest in such groups. Preventive measures must of necessity stress the recognition of early signs of emotional illness and provide facilities for prompt examination and treatment, as well as prophylaxis.

In specific reference to the problem of alcoholism, from the immediate practical point of view, we need to train more workers to treat the individual alcoholic; we need to set up more, and more adequate facilities, such as hospital wards, psychiatric hospitals, reception centers associated with mental hygiene clinics at which patients and relatives could receive help through diagnostic, placement and treatment services.

We are on the road to achieving these goals. With the cooperation of all groups having the same purposes, and with community and individuals' support and work, we should accomplish some of our aims within the coming years.

Meanwhile, it is definitely the obligation of all workers and educators to explain the fundamental facts of alcoholism to the community and to drive home over and over again that alcoholism is a symptom of a psychiatric disorder, illness or maladjustment; that the alcoholic cannot stop drinking at will and is different from other, social drinkers; that he can be helped, treated and rehabilitated; that the alcoholic in contemporary America is partly a product of our culture and its inherited and present strains and tensions; and that in addition to treating the alcoholic individual, we must help reorient our culture and social ways of thinking and living to a more decent, vital and spiritually productive level.

In brief summary, the non-psychotic non-deteriorated prisoner who sincerely desires to rehabilitate himself has, we feel, a splendid opportunity to take advantage of modern scientific psychological knowledge that will enable him, practically, to help himself and others in understanding that criminal be-

havior and alcoholism are not only waste products of a society that does not care about the individual's welfare but also of *individuals who do not care about society's welfare*. If he wants to, the prisoner can by his behavior do much to stimulate sound reforms in thinking about these very similar personality reactions—criminality and alcoholism, and to support sound ways of helping prevent their incidence in such large numbers; for, since truth is never hackneyed to those who desire truth, "Actions speak louder than words" and "As we would have others be and behave so should we behave and be." Therefore the prisoner who understands that his criminal acts were the result of emotional instability and poor integration of his personality assets that precluded his feeling and being a part of the social group, should understand that the use of alcoholic beverages would definitely reactivate these disruptive conditions; and he should for his own sake keep in mind that:

1. His period of being on trial extends beyond the prison sentence and parole: he must be prepared to meet with rebuffs in a mature manner of tolerance and forgiveness.
2. He, as an individual, has physical, intellectual and emotional drives which he must learn to control if he is to have any measure of "happiness" or inner security.
3. The use of alcoholic beverages (including beer and wine) always tends to relax self-control and to set free any underlying forces. Whether or not he feels that he has an alcohol problem, he should never drink again. From the down-to-earth point of view, he should recognize that the average man or woman naturally tends to be over-critical of the criminal, and a discharged criminal who is known to drink will necessarily be thought of with less confidence and more distrust than the known non-drinker. Conversely, the discharged prisoner who does not drink is given more moral support by the community and life is made considerably easier for him. There is here a definite

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choice the prisoner himself can make between the relatively easy and the relatively hard way of readjusting to and being accepted by the community.

In conclusion, alcoholism in America is a serious national health problem; the problem of criminality is closely associated in the personality field with alcoholism; neither the alcoholic nor the criminal (provided there are no organic or other serious states changes) should be viewed as hopelessly beyond rehabilitation. Society must assume its responsibilities on a realistic basis to help provide environments that do not tend to produce retarded or warped personalities; and individuals themselves must take some responsible purposive action along these lines and not, in an infantile manner, expect the community or the state to administer to all their wants and desires.

THE USE OF SEDATIVE MEASURES IN MENTAL HOSPITALS

LOUIS H. COHEN, M.D. AND THOMAS THALE, M.D.

In mental hospitals the administration of sedative measures must take into account the difficulty of treating a large group of disturbed patients who are housed on one ward with little opportunity for privacy or isolation. Often, due to insufficient or unskilled personnel, the patients are inadequately supervised, making it necessary to consider the stimulating effect of one patient upon another. Moreover, since many patients are hospitalized for long periods of time, various techniques and modifications of sedation are usually necessary from time to time. The quantity of sedatives prescribed for a ward of disturbed patients is often very large, and disastrous consequences sometimes occur because of routinization of ordering, carelessness in the dosages given, and ignorance of the toxic manifestations.

Among the sedative techniques the most valuable, probably, are the *prophylactic* ones^{14,21}. Under proper institutional conditions it should be possible to care for potentially disturbed patients by providing an atmosphere in which there is a minimum of provoking stimuli. The buildings or wards in which such patients are housed should be so constructed that only a small number of patients, preferably not more than fifteen, are in one group. There should be ample floor space over which this group might spread itself, with special rooms or sections for the care of the temporarily disturbed who might, by their noise and restlessness, excite others³. It is highly desirable that the acoustic properties of a ward for disturbed patients be such as to reduce the amount of noise. Attention to the maintenance of a uniform temperature is essential. Provision for out-door exercise is necessary, and the daily routine should provide ample opportunity for acceptable

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vigorous activity with only a minimal amount of idle time. Clothing should be comfortable, and careful attention and supervision should be given to the establishment of regular habits of bathing and elimination.

Special consideration should be given to the dietary program. The spacing of meals is particularly important, for it is well known that meal-time and the period immediately preceding it are probably the most difficult in the day for the nurses and attendants entrusted with disturbed patients. The relationship between hunger and restlessness has been pointed out as a characteristic of certain types of mentally ill persons^{13,19}. The food should be adequate in amount and presented at regular intervals. Long periods of waiting for food often provoke disturbances. Where possible, feeding between meals should be utilized. Meals should be served quickly, neatly, and with the least possible clatter of dishes and silver. Doilies, napkins and other attractive accoutrements of serving should be offered. While eating, the patients should be seated at such a distance from each other as to prevent bodily contact and snatching from each other's plates. Especially careful supervision should be maintained during meal time. Patients who are "feeding problems" should be kept separate from the rest of the group.

By maintaining an air of firm, quiet decorum, the nursing staff can do much to mitigate the atmosphere of excitement on a disturbed ward. Tact and patience are essential qualities in those caring for the mentally ill. The way in which the atmosphere of a ward becomes "charged" when it is under the supervision of a noisy, irritable or ineffectual nurse is a matter of common observation. The nursing staff must always be alert to hunt out any sources of excitement and to remove them. This necessitates a knowledge of the social organization of the group of patients, as well as close attention to individual idiosyncrasies.

Once a disturbance has arisen direct therapy must be instituted. Physical contact with patients by the supervisory personnel should be reduced to a minimum, and restraint of a

patient's motor overactivity should be attempted only under circumstances which will insure a prompt and safe outcome with as little struggle as possible on the part of all concerned. Almost always some kind of sedative medication also becomes necessary.

The disorders in which specific sedative measures are most frequently required may be grouped into three categories. First are the situations most commonly associated with *agitation*. The insomnia which often accompanies agitation may be so severe as to require the administration of sedative measures. Treatment should be instituted in time to produce uninterrupted sleep beginning at the usual hour without residual drowsiness (sometimes referred to as "sedative hangover"). In less acute insomnia the application of hydrotherapeutic measures, such as a cold wet pack or neutral bath of two or three hour's duration, may produce sufficient relaxation to assure the patient a night's rest. Such treatment, if effective, is preferable to chemical sedation. Often a combination of the two methods of treatment will be beneficial.

Agitation in the depressive states usually requires sedation, and sometimes demands it. The agitated patient may exhaust himself and become easy prey to illness as a result of his constant restlessness. The possibility of physical illness is enhanced by the fact that many of these patients eat poorly and become severely dehydrated. Infection or mutilation may result from picking and rubbing the skin. Most important is the danger of suicide.

Hydrotherapy is often ineffective in severely agitated patients, but less severe forms of agitation may respond quite well to prolonged baths of relatively long duration (4-6 hours). The temperature of the water should be between 96°F. and 98°F., and should be checked constantly with a hand thermometer. The cold wet pack is usually difficult for the restless patient to accept readily, and his struggles against this treatment often make it inadvisable.

For most agitated patients, prolonged chemical sedation is indicated. In some instances, sedative medication admin-

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istered three times a day and at bedtime will be effective in providing modification of the agitation, but in most instances it is necessary to produce sleep in order to bring about the desired relief. Prolonged narcosis, in which the patient is maintained in a sleeping state for a period of days or, in some cases, weeks, is indicated in extreme cases. This treatment requires specially trained and unusually capable supervisory personnel.

The behavior generally termed *negativistic*, such as refusal or inability to speak or eat or cooperate for routine care, can also be alleviated through the administration of sedative drugs. As a general rule, the effects are only temporary. Here the problem is not one of producing sleep or reducing overactivity as in the agitated patients, but rather of providing relaxation. The patient then becomes more responsive to others and may, if only temporarily, achieve better "contact". Intravenous administration of the barbiturates (sodium amytal, pentothal sodium) is the most common method. This treatment is a desirable alternative to the sometimes difficult and dangerous task of tube feeding.* The procedure has long been used as an aid in rendering the patient more accessible to psychotherapy. During the period in which the drug is effective (usually not more than an hour or two), the patient's contact with others is usually improved, his suggestibility is increased, and he may express previously repressed experiences. This treatment should not be used continually, or even at too frequent intervals, but under certain circumstances such as those described above, it may be astonishingly efficacious.

Of all the indications for the use of sedatives, the one most commonly encountered in institutions is that of *increased psychomotor activity*. This is manifested clinically in excitement, as general overactivity, or in special ways, such as assaultiveness, destructiveness, smearing, nudity, and shouting. Prompt and adequate treatment may abort an excitement or

*The usual procedure which has been quite successful in our hands has been to give the resistive patient sodium amytal gm. 0.5 intravenously about 15 to 30 minutes before the noon meal.

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minimize the extent to which the excited patient endangers himself and his surroundings. It should be emphasized that the basic disorder of the excited patient is rarely altered by the use of sedative drugs, and that only symptomatic relief is achieved. There are times when it is necessary to increase medication until sleep is obtained because the patient, although sedated, may still manifest his push of activity and injure himself while in a stuporous state. Here again the combination of hydrotherapy and chemical sedation may be more effective than either alone.

In evaluating the indications for sedative treatment one must, of course, look beyond the presenting symptom of agitation, negativism, or over-activity. The object of treatment is to produce a change in the behavior or experiences of an individual who is showing some specific form of undesirable behavior, or who is handicapped by his psychosis. Certain basic data must be taken into consideration. The age, weight and general health of the patient are important to know since there is a general tendency for older, smaller and weaker patients to have a diminished tolerance to sedation. There are reasons for believing that renal damage interferes with the excretion of the longer acting barbiturates and perhaps the bromides. Some patients have idiosyncrasies to particular drugs and react in an atypical fashion. The same drug in the same dosages administered to different patients may produce stupor, delirium or excitement, or no apparent effect at all. Such idiosyncratic reactions cannot be anticipated, but they need not occur more than once if proper records are kept.

Of greatest importance is a knowledge of the history, the probable severity and the duration of the symptom for which sedative treatment is contemplated. The conditions under which it arises are also important in determining the type of treatment prescribed. One may consider as a group the "acute reactive situations" in which depression, panic or excitement has clearly been brought about in previously composed individuals by some stirring experience. In such cases prompt and full sedation, perhaps sufficient to produce sleep for 24 hours,

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is of direct therapeutic value. In the more chronic states such sedation produces only temporary alleviation of the patient's distress, which is too high a price to pay for short-term relief.

It appears to us that the value of sedative drugs is often overestimated. Frequently, small doses are given either needlessly or in circumstances which call for more intensive medication. Evidence for this is the manner in which one highly valued drug after another has fallen into disuse. Today many of the "nervous" patients who formerly received elixir of bromides or of phenobarbital are deriving equal benefit from vitamin preparations. The effectiveness of any medicine may be merely a reflection of the physician's therapeutic optimism in the nurse and patient who are gratified to feel that "something is being done". When the more extreme sedative measures are considered it should not be forgotten that acute disturbances usually subside spontaneously. Unfortunately, there are few reliable measures of the effectiveness of sedatives on disturbances of various degrees of clinical severity. Objective studies of the efficacy of various drugs show that the usual doses produce very little effect^{22,10}. A contrasting but equally significant observation is that the amount of soporifics necessary to produce sleep in medical and surgical patients has been found to be amazingly small¹⁵. Our feeling is that medical and surgical patients usually sleep at night, and would probably do so even if they were not drugged.

It is practically impossible to mention every one of the many sedative drugs available today, just as it is impossible for the practitioner to know all of them. Fortunately, this task is as unnecessary as it is difficult. An understanding of the general principles of therapeutic sedation, along with a familiarity with a limited number of drugs having different characteristics, is adequate for usual clinical and institutional practice.

The same drug may be given through a variety of *routes*. The oral route, which usually is most convenient, is the one of choice. At times this method is not feasible because of the resistiveness of the patient. Rather than resort to tube-feeding

under such circumstances, one may give the medication through a rectal tube using double the dose. Drugs in solution are well absorbed from the rectum, but the fate of solid drugs is less certain. The rectal administration of medications, however, is often quite difficult with disturbed patients and the medication is frequently expelled.

Parenteral administration has the advantages of more rapid and more complete absorption. Sedative effects are usually apparent within a few minutes of intramuscular injection of any of the more potent drugs. Intravenous injection has the danger (and advantage) of producing almost instantaneous effect. There is some danger of overdosage in the case of an acutely excited patient when medication given intravenously is injected too rapidly. Subcutaneous injection is reserved for those substances which can be given in small amounts and which are relatively non-irritating. Chemical cellulitis or extra-venous leakage of the barbiturates often follows subcutaneous administration.

The most common *plan* of sedation is that in which the drug is given but once in sufficient amount to produce the desired effect. At times smaller doses are given repeatedly until the effect is apparent. This latter method is to be recommended in treating for the first time a patient whose tolerance is unknown, but it has the disadvantage of being difficult to control. Too often there occurs an unpredictable alternation between excessive and inadequate sedation with this procedure. The use of maintenance doses of sedative has been used in many institutions: good results have been claimed for this method of treatment, which is usually applied to a large group of patients. Initial sedation is often accomplished with one of the drugs of quick action, after which one of the drugs of sustained action is given regularly one to three times a day in amounts sufficient to produce some sedation but not intoxication. This form of continued sedation has been kept up for years in some instances, although more often the dose is gradually adjusted downward from time to time in the hope that a permanent effect will have been obtained^{4,5,6,24}.

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In the choice of sedatives it is advisable to select one or two from each of the following groups, based on the desired duration of action:

<i>Very long</i>	<i>Long</i>	<i>Moderate</i>	<i>Short</i>
Bromides	Sodium Amytal	Pentobarbital	Seconal
Barbital	Phenobarbital		Paraldehyde
			Morphine*
			Hyoscine**
			Apomorphine***

Certain serious dangers attend the use of sedative drugs. These are the development of tolerance, drug intoxication, and drug addiction. The rapidity with which tolerance develops is debatable. The same drug can probably be given several times a week for at least a month without losing its effectiveness¹⁰. In the absence of more definite information, it is advisable to change from one drug to another at monthly intervals.

Drug intoxication may be looked upon as an intensification of the usual sedative effects to an unusual degree or for an excessive time, or it may become manifest by effects such as delirium or intensification of symptoms^{30,25,27}. This condition is not unusual when one is using the maintenance plan of treatment. The usual signs of intoxication under these circumstances are those of incoordination, *viz.*, thickened speech, unsteady gait, impaired manual skill, positive Romberg and nystagmus. The treatment consists in withdrawal of medication and arrangement of the patient's routine so that he is not endangered by his incoordination. If acute drug intoxication occurs, it is manifested by failure to awaken, depression of reflexes, slowed pulse and respiratory rate. The treatment consists in the administration of stimulating drugs such as metrazol, coramine, picrotoxin and ephedrine, the maintenance of

*The use of morphine is probably never advisable.

**Hyoscine or hyoscine with morphine is sometimes of great but transitory value in frenzied excitements, producing a rapid easing of tension

***In using apomorphine, one is engaging in a procedure which has punitive as well as therapeutic aspects. It is well to bear this in mind.

nutrition by the parenteral route, and measures to prevent aspiration pneumonia.

Drug addiction as seen in institutions does not differ greatly from drug addiction elsewhere. The danger of addiction to long-continued drugs is ever-present, mainly because of the ease with which routinization of prescribing sedatives can occur. Morphine should never be ordered except where intractable pain may call for its use. As a purely sedative agent it should be completely taboo. Certain kinds of persons are predisposed to addiction, among them the dependent, depressed and hypochondriacal personalities. One should evaluate carefully the indication for sedating such patients after the first few days of their stay in an institution. In time, many institutional patients, even the most severely psychotic, may learn to feign symptoms or to intensify their excitements in order to obtain the desired drug. Sedative medications may come to have for them the same value in relieving the tedium of institutional life which alcohol has in the world outside. This state of affairs is an indication for the discontinuance of the drug or drugs and the use of other measures such as sedative packs, seclusion or sulfur-in-oil.

Some nurses and attendants, particularly those who place more emphasis upon the maintenance of order and routine than upon the individual aspects of the patients' welfare, are prone to feel strongly that every instance of noisiness or disturbance calls for disciplinary or sedative measures. The management of such personnel is an administrative problem whose satisfactory outcome is dependent upon an early recognition of the personalities involved. Naturally, it is administratively extremely important to have the supplies of sedative drugs available only to responsible and experienced persons. The following rules are obvious enough, but are repeated because of their great importance: drugs should be given only when an order from a physician is recorded in writing; standing orders and p.r.n. orders should not run for more than

three days; all patients receiving sedatives regularly should be watched carefully for the development of signs of toxicity.

In addition to the soporific drugs, other preparations have been tried with good results. *Sulfur-in-oil*, given by intramuscular injection, has been used with considerable sedative effect. This form of treatment, however, is followed by fever, malaise, and often by great local pain. The use of *vaccines* such as typhoid vaccine is said to have the same effect. The degree of sedation by these methods may be an index of the degree to which the patient becomes physically incapacitated, rather than of any frank sedative effect.

The systematic administration of *insulin* has also been used to decrease the activity and asocial manifestations of groups of psychotic patients². *Benzedrine sulfate*, 20 mgm. per day in divided doses, has been found to allay the restlessness of certain hyperkinetic children who have a six per second fundamental rhythm in the EEG¹². Recently, *dilantin* has been used as a sedative drug in psychotic patients¹⁷. A small group of chronically active aggressive, psychotic persons given one mgm. of *ergotamine tartrate* daily showed a decrease in the severity of these symptoms²⁹.

Shock therapy with metrazol-induced convulsions has been found to produce an amelioration of the symptoms of chronically excited, aggressive, destructive patients^{3,9}. Further experience with electro-induced convulsions indicates that the results are transient, and that treatments must be repeated. There is a tendency for the therapeutic effect to become less pronounced with each succeeding course of five to ten treatments. Better results have been claimed for the use of "maintenance doses" of convulsive therapy produced by electricity.

The use of *prefrontal lobotomy* has been reported by a number of authors^{11,13} who find that it is of great value in agitated and depressed states. The observation¹¹ that it was also of value in the treatment of chronically excited patients has been confirmed by subsequent studies, although there are some unfavorable reports.

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Sedation by *hydrotherapy* is of definite value, particularly as an alternative to medication in chronic excitement⁷. Neutral or cold packs exert a definite sedative effect in many instances of restlessness, and may be followed by a period of decreased activity after the termination of the three-hour period in the pack. Sedative hydrotherapy, however, produces its good effects much less regularly than does chemical sedation¹. There are many individuals whose motor drivenness is so great that pack or continuous tub treatment evokes only greater excitement. These treatments should not be administered to patients with debilitating diseases or with cardiovascular lesions. The techniques should be employed only when a properly trained hydrotherapist is at hand. Like lobotomy, hydrotherapy is a procedure whose application requires skill and experience, and should be administered only by a properly trained person.

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THE USE OF ELECTROSHOCK THERAPY IN CORRECTIONAL INSTITUTIONS

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I. Introduction

Electroshock therapy has now definitely earned its place as a very useful tool in the practice of psychiatry. It has already practically replaced metrazol, and also, to a more than moderate extent, insulin shock therapy. Electroshock therapy has become popular because of its obvious advantages over the other forms of shock therapies. It is easy to apply and very economical; it produces a complete amnesia, so that the patient does not have any unpleasant feelings whatsoever and is not unwilling to return for treatments (as is often the case with the other forms of shock treatment, especially metrazol); one can obtain not only a major reaction or grand mal seizure at will but can, to a great extent, control the severity of the seizure; the complications are less frequent; and finally the results, especially in the affective reactive types, are very gratifying. These considerations raise the possibility of its wider use in penal institutions.

Psychiatrists are aware that the prison population is prone to the same psychiatric illnesses as the population in general. The only difference found between the two is the greater incidence of psychosis in the penal group and the great prevalence of abnormal personality types, psychoneurosis, and psychopathic personality. Thus, one sees more anxiety states and psychoses with psychopathic personality in prison inmates. General paresis, alcoholic psychosis, manic-depressive and schizophrenic reaction types are not infrequently encountered.

The situation which leads to the imprisonment itself often precipitates a depression. This depression is often severe and at times leads to suicidal attempts. Depression as a symptom

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of other conditions, such as psychoneurosis is also often seen. The latter cases, with their frequent tendency to depression of the mood and their deeply-rooted feeling of inadequacy, represent an interesting field for the application of this form of therapy.

II. *Results*

In a paper published Nov. 1, 1943 in the New York State Journal of Medicine we analyzed 2000 cases treated with electroshock. These patients included our own cases and material from the literature.

TABLE I

ELECTROSHOCK					INSULIN				
	Cases	Rec	M. I. & I.	Unimproved.		Cases	Rec.	M. I. & I.	Unimproved.
ACUTE	391	26.6%	49.8%	23.6%		169	30.4%	41%	28.6%
SUB-ACUTE	128	7.7%	54.8%	37.5%		351	16.5%	35.3%	48.2%
CHRONIC	412	8%	30.3%	61.7%		475	41.8%	30.9%	64.3%

Acute. III less than 6 months

Sub-acute III 6 to 24 months

Chronic III more than 24 months

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Table I gives the results in our group of schizophrenic patients as contrasted with a group of schizophrenics treated with insulin shock. The findings indicate that the best results are to be expected in the acute cases where we should expect about 25% to recover and another 50% to improve. The results in the other two groups (sub-acute and chronic) are definitely poor. There is no appreciable difference in the results obtained from electroshock or insulin therapy.

It is interesting to note that, according to Malzburg, of 48,772 schizophrenics treated in 1941 in the New York State Civil Hospitals with methods other than shock therapy, only 1.1% recovered. In the same study we found that as far as type of schizophrenic reaction is concerned, there was scarcely any variation in the rate of recovery or improvement according to group, considering illnesses of the same duration.

A further study, to be published soon, was made by us on depressive conditions treated with electroshock therapy. Of a total of 2,519 cases of depressions of all descriptions published in the literature, we found that 90% were improved and only 10% remained unimproved. The study further showed that the improved and unimproved rates for manic depressive psychosis, involutional melancholia, and manic depressive psychosis of the mixed type are very similar, ranging between 52% and 58% in the recovered group, 32% and 35% in the improved group, and 8% and 11% in the unimproved group. In reactive depression 30% were found recovered, 61% improved, and 9% unimproved. We studied another group of patients in which depression appeared as a symptom in other entities, such as senile psychosis, psychopathies, etc. The results of this showed that of 78 cases, 16% recovered, 63% were improved, and 21% were unimproved.

The manic phase of manic-depressive psychosis also responds well to electroshock therapy. Of 184 patients, 55% recovered, 26% improved, and 19% did not improve.

A study of 282 cases of psychoneuroses of every type showed a recovery rate of 30%, improved 40%, and unimproved 30%. The general impression was that of the vari-

ous types, anxiety neuroses responded best, followed in order of rate of improvement by reactive depression, mixed psychoneurosis, hysteria, and neurasthenia. However, it must be admitted that this group, as a whole, is too small and not well enough defined for an accurate evaluation of the result of the treatment.

In general paresis, electroshock therapy has been used after malaria therapy in a limited number of cases. Broggi reports 9 cases, in 7 of whom convulsive therapy was followed by speedy improvement after malaria and specific treatment had failed to bring about a complete remission. Several cases, treated with convulsive therapy alone, did not yield satisfactory results. Peterson found that electroshock therapy is valuable in the treatment of dementia paralytica, as an adjunct to fever and chemotherapy. Of 16 patients, he noted improvement in all; this was more pronounced in the agitated and the depressed types. Tomlinson noted great improvement in 4 out of 5 cases of general paresis who had received malarial therapy and tryparsamide followed by electroshock. Yasukoti and Makasa noted the disappearance of auditory hallucinations in a case of general paresis.

To illustrate the results of this treatment in cases of general paresis, the following personal case may be of interest: A. B., 45, was referred for electroshock treatment after malaria therapy. The patient was extremely agitated, uncooperative, dirty, talked incessantly and needed continuous restraint. After the fourth electroshock treatment he calmed down considerably, was in better contact, very much easier to manage. After an intensive course of penicillin he had a complete remission and has since returned to work.

Psychopathic personalities have been only rarely treated with shock therapy. Bennett noticed no improvement in 4 psychopathic states treated by him because of depressive and anxiety features. Golden reports on 4 psychopathic personalities with depression, in 3 of whom he obtained improvement. Banay, out of 51 cases of psychopathic personality with emotional instability, reports beneficial reactions in all patients,

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while psychopathic personalities with paranoid tendency (12 cases) reacted less favorably. No other results with these types of patients have been published thus far, but it is apparent that in psychopathies one may obtain at best a symptomatic improvement. In itself this is a considerable advantage, in view of the difficulty of management of these inmates. We feel that a more extensive use of convulsive therapy in selected psychopaths would be highly desirable, in order better to evaluate the possibilities of this type of therapy.

Reports of results in alcoholics are limited, as yet, and do not lend themselves to statistical evaluation. It appears, however, that the therapy has a definite field of application especially in the treatment of dipsomaniac crises. These seem to be interrupted promptly by the administration of one or two treatments. No results can be achieved, of course, in cases of advanced alcoholic deterioration, but there is reason to believe that alcoholic psychoses may be improved by convulsive therapy.

A most important field of application of electric convulsive therapy in a hospital for the mentally ill is its symptomatic use in chronic, uncooperative, destructive and agitated patients. Although recovery cannot be expected in these cases, the improvement in behavior which results after shock therapy is a definite gain. Several authors agree that a high percentage of behavior improvement can be achieved in these patients with a corresponding diminution of acute nursing problems. The improvement is especially noticeable in overcoming such symptoms as insomnia, refusal of food, hallucinations, aggressiveness and destructiveness. Low grade hyperkinetic mental defectives can also benefit from the treatment. In these cases it is preferable to give, at first, 6 to 9 treatments in 3 weeks, this to be followed by 1 to 4 treatments a month as required. It is reported that no deterioration of the personality was found in patients who had received this type of therapy even for periods of more than two years.

According to some reports, electroshock treatment is also

being useful in epileptic cloudy states and in the discharge of psychic equivalents especially following large doses of barbiturates.

Finally, we think it may be of interest to mention the only work on electroshock therapy in a correctional institution thus far published, to our knowledge. This is a paper by Ralph S. Banay, formerly of Sing Sing prison, who treated a considerable number of inmates manifesting early signs of mental illness, with the purpose of avoiding, as much as possible, the development of major psychoses. According to Banay, there were favorable responses in 22 cases of beginning hypomanic state, 48 cases of depression, 51 emotionally unstable psychopaths and 30 psychoneurotics with reactive depression. Twelve psychopaths with paranoid tendencies and 13 alcoholics with emotional instability reacted less favorably to the treatment. No improvement was noted in 34 patients with schizophrenic manifestations. It is interesting to note that these results were achieved by rarely using more than 5 treatments for any one patient.

In summary, we would like to emphasize that establishing an indication for electroshock therapy requires careful evaluation of the individual patient's condition, as well as a clear insight into his personality, his assets and his liabilities. This, of course, requires experienced psychiatric judgment.

III. *Technic*

The treatment is usually given two to three times a week. In our experience we have found that two treatments a week are adequate in most cases, but we have given three treatments a week to patients with severe depressions until improvement occurred, and then followed with two treatments a week. Some patients with severe involutional paranoid psychoses have been given the treatment to the point of confusion with good results. This consists in treating the patient every day or every other day until he is confused, at which time the treatment is stopped. After a week or two have elapsed, both the state of confusion as the result of the treatment and the patient's original symptoms may have disappeared. If the patient still shows

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psychotic symptoms, the procedure is repeated once or twice until he finally clears.

To illustrate, J. F., 52, had had a severe involuntional paranoid syndrome with systematized delusions of persecution and frequent auditory hallucinations for several months. He received 11 treatments, at the rate of two a week, with no improvement. He was next given five more treatments at short intervals until he was markedly confused, after which treatment was stopped. At this time the patient was still very delusional and hallucinated, very uncooperative, and refused to eat because he thought his food was poisoned. About two weeks later he began to improve. The improvement continued steadily and, after six weeks, all signs of psychosis disappeared. He has been well since then.

The number of treatments to be given to any patient cannot be predetermined, as only the response of the patient determines how long he should be treated. In general, treatment is continued until all symptoms of the psychosis have subsided. Depressed patients usually require 6 to 12 treatments, while patients with schizophrenic psychoses and involuntional paranoid syndromes require from 15 to 30.

To treat a patient efficiently and safely, a physician and three assistants are required, as the management of the patient before, during, and after the treatment calls for considerable experience. It is desirable that the same team be used for successive treatments.

Reluctance to submit to treatment is sometimes the first difficulty encountered. Fortunately, relatively few patients show apprehension, fear, or antagonistic behavior. Most of those who resist are negativistic schizophrenics and markedly agitated depressives who would, in any event, resist any form of treatment. We manage these cases by the administration of 0.5 mg. of sodium amytal intravenously or intramuscularly. Almost immediately after the intravenous or 15 minutes after the intramuscular injection, the patients lose their fear and resistance and submit to the treatment without difficulty.

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Before the treatment, all dentures are removed and the patient is asked to urinate to avoid wetting the bed. After the electrodes have been put in place he is told to clear his nose and throat. This precaution is taken to avoid breathing difficulty and aspiration of mucus after the seizure. We have found it unnecessary, except for those who habitually vomit after treatment, to require that patients fast before treatment. The vomiting that occurs infrequently after treatment has no relation to the food intake and may occur also in fasting patients.

During the treatment the patient is placed on a reasonably firm and wide bed. To avoid fractures of the spine and extremities, the back must be arched over a tightly rolled pillow placed under the mid-thoracic region; the lower limbs are held in extension and adduction while the upper limbs are held close to the body. In some cases a thin pillow is placed under the head. Two assistants, one on each side of the bed, hold the patient down. The physician, who places himself near the patient's head, holds the jaw and operates the apparatus. At a signal from the operator, the assistants press down and maintain the pressure throughout the treatment. With particularly strong patients it is better to have a fourth person to keep the legs down by placing a pillow over the knees and leaning heavily on them. The amount of pressure to be exerted is a matter of individual experience; muscular individuals will require the application of the full weight; women, especially if of a small and fragile build, will require much less pressure. In each case, an effort is made not to suppress motion completely, but to meet the sudden initial jerk with an elastic and well-regulated resistance in such a way as to ease the stresses caused by sudden violent muscular contractions on the bony structures. Special cases may require particular attention. A patient with severe osteoarthritis of the spine required the placement of 2 additional pillows under the shoulders, as well as one under the head. He was held firmly in such a way as to minimize movement as much as possible. One patient with a relatively fresh fracture of the tibia, which was

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held together by two screws, and another with a marked post-traumatic deformity of the tibia, were treated without accidents by having an assistant hold the affected leg firmly in order to avoid sudden and excessive movement. Another patient with severe thinning of the clavicle following osteomyelitis has been treated successfully by holding the shoulder carefully in place with a hand applied flat and firm over the head of the humerus and the outer end of the clavicle.

During the treatment the mouth is protected with a gauze-covered, soft rubber tube inserted deep enough to bear on the molars and bicuspid. Sometimes a patient refuses to have the gag placed in his mouth. If this is the case, he is instructed to keep his mouth closed and as he opens his mouth widely at the beginning of the tonic phase of the convulsion the mouth-piece is quickly inserted and held in position. To avoid dislocations, the jaw must be prevented from opening very wide by gentle pressure especially during the tonic phase.

At the end of the convulsion the patient is kept in hyperextension until the respiration is well established. Often we find it convenient to stimulate respiration by rhythmically raising and lowering the arms and exerting slight pressure on the chest. In some patients, as respiration begins, it is evident from a gurgling sound that some fluid is obstructing the air passages. In such cases, the air passages are drained very simply by turning the patient on one side, with the head hanging over the side of the bed. This postural drainage facilitates the elimination of the saliva and mucus through the nose and mouth. After the respiration has returned to normal and the cyanosis has disappeared, the patient is replaced in the original position. In only very exceptional cases have we been confronted with alarming apneas. One patient who had received curare prior to the treatment required artificial respiration and intravenous prostigmin. Two elderly women needed intravenous caffeine and artificial respiration. The possibility of these alarming apneas emphasizes the necessity that the physician administering electrofit therapy is well trained in the management of this complication.

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At the end of the seizure, if the patient shows signs of excitement, it is advisable to handle or restrain him as little as possible in order not to increase the excitement, fear and bewilderment. The excitement lasts from one to two minutes, following which the patient usually falls asleep. If an excited patient attempts to get out of bed he should be prevented from so doing. The ushering in of a relative or friend whom the patient recognizes often has a calming and reassuring effect. Patients who become excited after the first treatment should be given sodium amytal 0.5 gm. intravenously prior to the next treatment as this drug effectively prevents post-treatment excitement.

The patient should remain in bed until he feels inclined to get up. Before he leaves he should be seen by the physician, who should ascertain if the patient has pain in the spine, headache, or other complaints. When a patient complains of back pain, especially in the upper thoracic region, he should be X-rayed at once.

As a whole, the entire procedure should be carried out as simply as possible. This helps the patients to accept the treatment as a matter of course.

IV. *Complications*

A detailed study of the possible complications of the treatment may be found in our article referred to above. The most common is compression fracture of the thoracic spine, the incidence of which is about 2% in a series of 1750 cases. Despite all the precautions we have outlined and the use of an experienced group of assistants, this complication is often unavoidable. However, its importance should not be over-emphasized. Although a spinal compression fracture may be quite painful for several weeks, the experience has been that even in the cases of multiple fractures there was complete healing with no orthopedic or neurological complication. B. L., 42, a powerfully built male, was referred for treatment during his fourth episode of depression. All the previous episodes lasted about a year; the present one was of six weeks

duration. At the first treatment he sustained a compression fracture of four vertebrae (Th5 to Th8) with moderate angulation and intense pain. The patient was placed in a spinal brace and it was decided, in view of his extreme depression and the danger of suicide, to continue his treatment irrespective of any possible aggravation of the fracture. Four additional treatments were given, and complete remission resulted. Prior to each treatment the patient was placed carefully in extension on soft pillows, and a determined effort was made by five assistants to immobilize the patient and avoid any movement of the spine. Except for a slight increase in pain after the fourth treatment there were no apparent ill effects on the fracture. The pain subsided three weeks after the end of treatment. Immediately after the end of the treatment the patient resumed full activity. These patients usually require no special provision other than strapping of the back and advice to avoid excessive motion of the trunk. In only two cases were we obliged to have the patient wear a spinal brace. Two other patients who had sustained spinal fractures during treatment for a previous depression required a further series of treatment on account of a recurrence of the depression. This time they were given curare intravenously prior to each seizure and went on to recovery without any additional injury to their spine. Of course, in every case where a compression fracture occurs, an orthopedic consultation should be had.

Occasionally the treatment may produce fracture of the long bones, hip bones, clavicles, scapulas and mandibles. The total incidence of all these fractures is smaller (about 1%) than that of compression fractures of the spine, and the frequency of their occurrence can be lessened by proper handling during the convulsion. Muscular aches, especially of the back, activation of arthritis and activation of subdeltoid bursitis have been reported as the result of the treatment.

Activation of pulmonary tuberculosis, lung abscesses, pneumonia and pulmonary edema in the course of treatment have been reported. However, we would like to stress that these complications are exceedingly rare. In over 600 cases

we had not had a single pulmonary complication with the very questionable exception of one patient who developed a lung abscess following pneumonia which had developed during a course of treatment. The pneumonia occurred in the right upper lobe, which makes it improbable that it was due to aspiration and, therefore, to the electroshock treatment.

Since Lieber wrote his paper in 1941 on activation of pulmonary tuberculosis following metrazol shock therapy, this complication has been feared and looked for following electroshock therapy. Careful study of the literature of electroshock therapy shows that out of many thousands of patients who had completed their treatment, only a few have had this complication. It is our feeling that activation of pulmonary tuberculosis is not caused by electroshock therapy but is rather a coincidental phenomenon. As a matter of fact, we have treated a small number of cases with known pulmonary tuberculosis with complete success and without aggravating the pulmonary condition. One of these patients, J. M., had a tubercular infiltration of the right apex with positive sputum and moderate haemoptyses, the last of which had occurred about three months prior to the beginning of the treatment. When therapy was instituted for a severe attack of manic depressive psychosis, depressed type, he had no signs of activity but was still considerably emaciated. He recovered from his depression completely after six treatments, with no ill effects.

Prolonged apnea is an infrequent occurrence. It is slightly more frequent in patients who have received intravenous sodium amytal prior to the treatment. If the patient does not breathe within 30 seconds from the end of the convulsion, artificial respiration should be given by raising the upper limbs above the head and back to the sides at the rate of about 15 times per minute. Concurrently, the head should be moved to either side and the jaw brought forward. If this does not help, the standard forms of artificial respiration should be employed. Particularly alarming and threatening apneas occur in patients who have received curare injections prior to treatment. In view of this fact, as well as that 4 out of 8 cases

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of death reported thus far had received curare prior to the treatment, we feel that curare should not be used routinely, and then only by physicians who are trained and competent in its use and know how to handle any possible complication. We gave one of our cases an injection of 3 cc. of intracostin (curare) because he had previously sustained a spinal fracture. This was followed by practically no muscular weakness. The dosage was raised 10% at the following treatment. As usual, the patient's muscular strength was carefully tested two minutes after the end of the intracostin injection and his muscular power was apparently unchanged. About one minute after the end of the convulsion the patient's aspiration became shallower, and within another minute ceased completely. This was accompanied, of course, by an extreme degree of cyanosis. He was given artificial respiration and two injections of prostigmin. The respiration began about 5 minutes after it had ceased. The patient suffered no ill effects, and with a few more treatments given without using curare he had a complete remission of his mental illness.

In our review of the literature we have found 8 deaths out of an estimated 11,000 cases. The causes were dilatation of the heart, myocardial damage, ventricular fibrillation, coronary occlusion, pulmonary edema, pneumonia and post-convulsive respiratory arrest. The evidence available thus far indicates that in no case was death caused by direct injury to the brain. It is a fair estimate that perhaps several of these cases would have died irrespective of the treatment.

V. *Contraindications*

Contraindications to the treatment are severe cardiac or pulmonary conditions, osteoporosis, severe cachectic states, hyperthyroidism, and any severe general illness. It is necessary, however, to point out that the evaluation of contraindications requires individualized judgment and considerable experience on the part of the psychiatrist. In cases where the patient's life is endangered by possibility of suicide or exhaustion due to agitation, only a serious contraindication is admissible. This

view is supported by a large number of reports of successful treatment of patients afflicted with severe diseases of the heart, lungs and bones, as well as by emaciation and pregnancy. In this connection, we have treated in our own personal cases a number of patients who could well be considered very poor physical risks. Among these there were three cases of auricular fibrillation (all well compensated) and one of the patients had previously suffered from coronary thrombosis; another had a gastric ulcer which bled very easily. Several of the women were pregnant, one at the fifth month when treatment was ended. Several of our patients were over 70 and severely emaciated. Many patients had blood pressure over 200 systolic and 120 diastolic. One of them, with a very severe involutional psychosis, had a blood pressure oscillating between 250 and 300 systolic. The latter, however, was given only non-convulsive treatment. One of our patients with an exceedingly severe manic state had suffered six months previous from a cerebral thrombosis with complete left hemiplegia. He was treated without ill effects and made a complete and stable recovery after four grand mals. A female patient who had recently undergone a fixation of the elbow at right angle following a neglected fracture-dislocation was given treatment immediately after removal of the cast. In this case, prior to treatment, we fixed the arm in the old cast: it had been split in two and the two halves were tied firmly together. In none of these cases, were there any ill effects from the treatment. Almost all these patients recovered from their psychiatric conditions.

Treatment of poor risks obviously requires mature experience and an accurate weighing of all the factors involved.

VI. *Conclusions*

Concluding this short review of the present status of electroshock therapy, we wish to express our hope that this method of treatment will soon be routinely applied in well-selected psychiatric cases seen in prison. Its use promises ample reward to the physician engaged in the treatment of the criminal who is mentally ill. It opens the possibility of a cure to a

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large proportion of psychotics and a substantial symptomatic improvement to some psychotics, psychoneurotics, and psychopaths. The treatment should not, it must be understood, replace psychotherapy. In fact, it is advised that psychotherapy be given during and following shock therapy. In some psychoneurotics a small number of treatments may, by breaking through the patient's superficial resistance, make him available for psychotherapy.

PSYCHOTHERAPY IN A PRISON SETTING

NATHAN BLACKMAN, M.D.

The psychiatrist has two functions in a prison:

(1) To maintain the mental health of the prison population.

(2) To enlarge the social scope of the inmates and strengthen their identification with society.

The psychiatrist is faced with a prison population which has but little inducement to carry on, especially those individuals who have long sentences and whose moral stamina, in face of a monotonous and dreary existence, is none too strong. There are a number of inmates who, when faced with the stark reality of a prison sentence, tend to evade the sense of personal failure by resorting to escape mechanisms. These people may drift into a psychosis, or blame their inability to function effectively on physical incapacities. They accentuate their physical ailments and appear totally incapable of coping with their problems both as far as the daily existence within the prison is concerned as well as the long-range problems that will face them in the future. These inmates, in the grip of a psychotic reaction, or in the process of translating their social frustrations into terms of physical ailments, need psychiatric guidance.

This guidance and understanding of the mental processes of the inmate is even more important as a means of preventing the onset and perpetuation of mental symptoms often difficult to eradicate once the inmate has learned to lean on these symptoms as a means of escaping the monotony of prison existence. The tendency to revert to a state of helplessness, to receive succor because of ill-health, real or fancied, has to be fought if the inmate is to learn to face his future and shoulder his responsibilities.

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It is preferable not to make the inmate aware that he is obtaining concrete benefits from his mental illness. The hospitalization of an inmate in the throes of a mental disorder can often be postponed by increasing the care and supervision accorded to him while he remains a part of the prison population. Closer supervision, a work change, transfer to a separate cell, frequent visits to the psychiatrist, insistence on a medium of self-help and activity—all of these steps are means of alleviating the mentally-disturbed prisoner's adjustment. At the same time, the prisoner is not allowed to discard entirely his responsibility in meeting the reduced exigencies of prison-life. There is always the possibility that, if the prisoner has once succumbed to a mental incapacity, there will be little incentive for him to discard the mental symptom. It is worthwhile to apply all possible measures to maintain the inmate within the routine and discipline of the institution.

The individuals needing this form of psychotherapeutic supervision are usually found among the labile psychopaths, the psychoneurotics, and the mental defectives. The following cases in each category will illustrate their successful handling within the prisoner population, without resorting to hospitalization.

Case 1. Twenty-six years old, married, has a longstanding history of social mal-adjustment, poor work record, minor escapades with the police, a generally irresponsible and inadequately motivated outlook towards his social responsibilities. There is no history of psychotic episodes in the past. He is seen by the psychiatrist because of multiple paranoid complaints. He appears self-absorbed, talks in a rambling, superficial manner about being an illegitimate son of the President, having to live incognito, being persecuted because of his beliefs in the constitution, etc. He misinterprets and elaborates on various passages in the Bible to prove that the country is being over-run by the Reds. Throughout his nonsensical ramble there is a superficial smile on his face, his mood is somewhat elevated, but he is in good contact with his environment. He is aware of having to serve a fairly long sentence, but has

difficulty both in accepting the responsibility for it and in carrying on the daily prison routine. It is his first serious setback in life. Up to this time he always managed to squirm by without being penalized for his various failures.

The therapist, while giving credence to the inmate's multiple complaints and confabulations, succeeded in distracting the inmate to a point where a certain kernel of disbelief in his psychotic production was left with him. The inmate was allowed to return to his job in the carpenter shop. The supervisor of the shop was advised that the individual needed more constant supervision. Arrangements were made for his placement in a cell where more privacy as well as closer supervision could be exercised. The inmate was seen about twice a week for psychotherapeutic sessions. A strong impression was made on him that a resort to psychotic mechanism for escaping his reality situation carried its disadvantages. At the same time, various inducements and real interest in his problems promised him more understanding and helpfulness in meeting his every day problems.

Within two or three weeks the psychotic production began to diminish. The inmate still remained mildly euphoric and was probably certain that he took the "therapist for a ride." However, he had no compensatory gains as a result of this psychotic episode. No lasting neurotic tendencies remained. His likelihood to continue in good mental health, and to carry out the sentence, which his transgression called for, had become more assured.

This case represents a psychotic episode in a labile psychopath. Although these episodes are known to be transient and correspond very often to "blowing one's top" in the psychopath's vernacular, the possibilities of heading off a major psychotic reaction is important to be aware of. This individual was actually under treatment while continuing to be ambulatory in the prison population. His daily routine and degree of responsibility for disciplinary infractions was lightened. Still, for this self-absorbed and obviously fragile mental condition, the psychotic situation did not represent

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any advantages beyond the rapport with the therapist which, however, hinged on his ability to loosen the tendency of letting his imagination wander.

If hospitalized, the same individual might also have recovered quickly from the psychotic episode. However, the leisure and dependency of hospital existence, the realization that he had become a source of worry and concern for the hospital staff, the lack of impetus or need to escape the ward situation, might have retarded and occasionally inhibited a ready recovery from this almost "self-induced" psychotic state.

Case 2: A 34 year old male, college graduate who had an unusually good reputation in his community is serving a sentence of six years for an offense of pedophilia. This trait has been latent for numerous years, and except for sporadic approaches towards minors, the present offense has been the first involvement with the law. The subject has been diagnosed by another psychiatrist as schizophrenic. He is correctly oriented, in good contact with his environment, asks almost pathetically for reassurance and help and is full of remorse, anxiety, occasional suicidal urges, as well as ideas of "deja vu", obsessive reactions, continuous imprecations to have his family told the truth, and at the same time hoping that they, including his fiancée, will not learn about his offense.

In face of this reactive depression with the underlying guilt feelings and an almost conscious desire to escape the humiliation and monotony of his sentence, an attitude of calm, impartial, though at times stern, reassurance was resorted to. The individual continued to work in a labor detail; arrangements were made for him to become absorbed in religious activities. He was seen at frequent intervals by the therapist; during these interviews he gave vent to considerable verbal catharsis. Instead of the schizophrenic-like reaction which undoubtedly existed at first, the picture became that of a sexually mal-adjusted neurotic individual, whose mother fixation and sexual aberration have not been cured, but who has learned to better control the acute panic and personality disintegration

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that the prison sentence provoked. He was not aided into escaping his situation by magnifying the seriousness of his mental state.

During the period of psychiatric observation the subject was part of a group, did manual labor, had to tend to his meals and toilet, had to conform to the disciplinary regime. The concern and interest of the therapist were contingent on his model behavior as an inmate. Without his knowledge, suicidal precautions and close observation were extended. The weekly visits to the therapist, the degree of catharsis, and the morale-building reassurance sufficed to keep the inmate from escaping totally into a retreat from the harsh reality that confinement represented for him.

Case 3. A 24 year old mental defective (mental age: 9 years; I. Q. 70) had completed about one year of confinement when he began to act in a bizzare manner, suddenly talking to strangers as if they were his close relatives, acting out playful imaginary situations, such as fishing from the stairs of the building, and talking in a confused, disconnected jargon. The picture was obviously that of a psychotic episode in a mentally defective individual. He has been described as always having been the "town fool", inclined to do exaggerated things, bragging considerably, but seldom being involved in any serious altercations. He had another six months to serve.

He was removed from his work detail and temporarily assigned as a wing orderly. The supervisors were instructed not to be exacting about his work performance. He continued to go to the cafeteria and, except for the work change and fairly frequent visits to the therapist, no change in his status was carried out. The psychotic production subsided within one week, the inmate having realized that no short-cut to his penitentiary sentence would be achieved by this mental reaction.

Case 4: A 22 year old individual, who was raised in a middle-class family has been a juvenile delinquent, repeatedly causing embarrassment and concern to his parents, being the "black sheep" of the family since early years. He repeatedly

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ran away, roamed throughout the country, and caused his family anguish as well as considerable financial expense each time he had to be retrieved from a new predicament. Numerous attempts to get him adjusted into an occupation or business failed.

In confinement, he started on a series of recalcitrant disciplinary infractions, he became negativistic, showed masochistic trends such as scratching the name of the warden on his arm, and refusing to eat his meals. He was in good contact with his environment, but was careless of his personal habits and showed a dependent, cringing, careless attitude, with most of his acts apparently calculated to attract attention and cause disagreement and discomfort to those in charge of him.

After several forced feedings and a few apomorphine injections, the overt aggressiveness subsided and he became more attentive to his personal appearance. Gradually the bizarre behavior quieted and, although still a special problem as far as adjustment was concerned, the psychotic manifestation disappeared, and he was able to be released at the time his sentence expired.

The important common factor in these cases has been the readiness to escape the hum-drum existence in a prison by resorting to psychotic escape mechanisms. The therapist's role was to ease the prisoner through the psychotic episode without bringing too obviously into his consciousness that there were compensatory gains resulting from this episode. It is easier to lock up a suicidal patient on a hospital ward, and by doing this feel fairly secure that he will not commit suicide as long as he is on the ward. To exercise the same degree of supervision without isolating the person from his daily routine requires more ingenuity. The mildly psychotic individual may be a source of worry and concern as a member of a group. But with the prison personnel aware of this indirect therapeutic approach, with any idea of punishment or severity excluded, the chances for a swifter recovery are ample reward for the additional concern the moderately disturbed individual may have caused.

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The guidance of the shy, insecure, basically retiring and inadequate individuals can thus be accomplished by individual, closely-paternalistic supervision. The various hypochondriacal complaints usually cease once the prisoner realizes in the therapist a strong will to correct and guide the prisoner through his mental vagaries and incertitudes. Even the dramatic "blowing one's top" subsides upon the realization that the parent-object, the therapist, is not at all concerned or affected by the dramatic display. Mild censoring, a certain degree of ego deflation, combined with face-saving reassurance and a profession or readiness to help the inmate once his emotional display has subsided, often suffice to bring him back to reasonable self-control. Even the mildly paranoid or childishly simple mental defectives are helped through an acute outburst by leaning on the therapist in an indirect, imperceptible manner, rather than by hospitalization.

At times a particularly stubborn flight episode can be cut short by administration of apomorphine (1/10 grain), forced feeding by stomach tube, or intravenous Sodium Amytal, with its resultant psychic catharsis.

The following case illustrates some of the dangers of handling the mentally disturbed patients among the prison population.

Case 5: A 27 year old individual who is serving a sentence of five years, had a history of periodic headache, sensations of pressure over his eyes, pain, and blurred vision since adolescence. These spells of pain and impaired vision occurred about once or twice a year and it is reported that he would stay at home for one week or two, sometimes tearing his clothes because of the anguish and pain. He worked in a store for about six years, was an agreeable and well thought of person. The eye symptoms caused him to lead a more restricted existence, and he received more attention and concern within his family circle and at his place of employment because of his infirmity.

During his stay in prison he was hospitalized, and a

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thorough study revealed no physical reason for the symptoms of which he complained. Evidence of mother-fixation, sexual immaturity, and inadequacy were elicited, and the symptoms of the blurring of vision was considered to be functional in nature. The patient was diagnosed as psychoneurotic. As the period of hospitalization was getting prolonged, an attempt was made to adjust the patient to a return to the inmate population. After considerable reassurance he was finally assigned to a janitor's job in the prison chapel. He complained of the noise in his cell wing and was allowed to reside in a single cell. Within three days he made a suicidal attempt by jumping from the third floor, following which he lapsed into a serious depression.

It is quite possible that the awakening of sufficient understanding of his difficulties in life, without the opportunity of sublimating and utilizing his psychic energies in a constructive activity, exposed this individual to more strain and psychic turmoil than did the existence of his physical complaints.

Constant watchfulness has to be exercised in handling these transient psychotic reactions. Removal to a single cell is, of course, indicated. The guards must be alert for the appearance of psychotic symptoms indicative of a deeper regression to infantilism which may necessitate hospitalization. Suicidal attempts call for additional precautions. Still, the number of prisoners that can be led through psychotic reactions and regain an even better control of their emotions is proof enough of the advisability of what may be referred to as the "conservative" approach. The prisoner is not punished, he is not maltreated during his period of mental upheaval. He is aided, his adjustment is supervised, his reaction understood and condoned, but he is not made aware of "getting away with it." No clear-cut break with his prison situation is allowed. The inmate continues as a member of the prison population. The resultant stabilization of the prisoner's mental health maintains society's intention in imposing the sentence, while the prisoner has gained additional strength and ability for self-control.

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The tendency to focus one's mental difficulties into physical complaints is encountered fairly frequently. Once the symptom has become fixed, and the inmate has received concrete benefits because of these symptoms, psychotherapy will be of little avail. The following case illustrates the role of somatic symptoms.

Case 6: A 29 year old individual who was raised as an orphan, and who, after hard years of struggle, finally secured a well-paid job as a saw-operator. He was married, had two children, and led a responsible, fairly secure, existence. He worked for seven years in one place and he is described by his employer as less alert, nervous, and suspicious for about a year prior to his present offense. His wife writes that he had cramps and burning sensations in his right foot for about three years, and a physician once diagnosed his condition as due to "latent" phlebitis.

Since entering the prison he began to complain of tightness in his leg, walked with a limping gait, and claimed that he could not do hard labor. A period of hospitalization was recommended in order to rule out any physical causes for the limping gait. The absence of any physical reason for his complaints confirmed the belief that he was focusing his distress and feeling of failure into this symptom. In spite of his protestations he was returned to a somewhat lighter job, monthly interviews with the psychiatrist, were scheduled to follow his progress, and the complaints of cramps as well as the abnormal gait subsided within several months.

On the whole, the inmate who has become confirmed in his belief that he has a physical incapacity is extremely resistive to treatment. He has frequently achieved a definite gain from his symptom. His emotional conflicts are less acute as long as he can rationalize to himself that his failures are due to an infirmity which to him is physical in nature. Sometimes sufficient reassurance and definite steps to find an occupation for him helps the individual to lessen his hold on the infirmity or symptom. Several cases seemed to benefit from participation in group therapy sessions. But the greater number of these

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individuals had complaints and symptoms which had lasted for long periods, and the outlook for a complete recovery from their symptoms was none too good.

The psychiatrist's function to increase the motivation and insight of the inmate population can best be accomplished by group therapy methods.

The non-conformist who winds up in a prison is not mentally unbalanced, although his concepts of moral values and his emotional tone is out of step with that of the population at large. The inmates, while not in retreat from reality, have digressed from normally accepted patterns of behavior. Their motivation has been on a level of infantile wish-fulfillment, they have shown a disregard for the consequences of their acts, they have chosen to risk rather than to evaluate and to consider.

Although various degrees of reality disevaluation might have existed, the contact, the availability of a rationale, can often be elicited from the inmates. In contrast to individuals who justify their evasion of reality by resorting to neurotic or psychotic reactions, the men in correctional institutions not only accept the existence of the world around them, but have openly defied and challenged the structure and moralities of a society which restrained or hampered them.

We have in prison individuals who exteriorize their conflicts on to social structures rather than—as in the case of mentally handicapped individuals—resolve their difficulties of adjustment by inwardly directed psychotic mechanisms.

In working with a prison population the psychiatrist is able to stimulate and influence social adjustments to a degree often impossible with patients with whom contact and rapport is difficult to obtain. That does not mean that rapport with these basically immature and socially mal-adjusted persons is an easy thing. Still, the innate motivation is there, although often the emphasis is placed on one or another basic urge with the incidental loss of a balanced view toward the exigencies of society.

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The difficulties that beset a group of psychotherapy methods are manifold. Perhaps the most striking one is the inability to impose postulates of adult behavior onto individuals who are basically immature. How to install respect for social structures which have, in the eyes of the inmate, been unjust or harsh? How to steer the individual from his bravado air and identification with the anti-social into normal ways of behavior? Mere talking, the gaining of insight on a superficial level, is often inadequate to supply the stimulus needed to draw the inmate from his solitude and to counter-act his rejection of social postulates. To promote a change in outlook, to inspire new postulates or beliefs, requires group identification. The prison population, as a whole, needs to be oriented in patterns of mature behavior. The exercise of influence, the education and stimulation of large segments of the inmate population, can bring better results than fragmentary, isolated attempts at indoctrination or enhanced motivation. While the confirmed criminal may not be subject to genuine improvement, a good percentage of the immature, socially inadequate non-conformists would accept an identification with a group, and would go along in the reorientation as long as they are allowed to identify themselves with the group.

In the application of group psychotherapy the ingenuity and enthusiasm of the therapist are its only limits. The application of group discussion and case presentation in a hospital setting have led to very encouraging results. (1) A somewhat similar technique was applied to a group of military prisoners, where such predisposing factors as paternal aggression, mother fixation, emotional dependency, the role of sex, and the function of the individual in society have been discussed. (2) In this group therapy project the stress was placed on the increase of understanding of the prisoners into the mechanism responsible for their misdeeds. Groups of twenty to thirty prisoners met twice a week with the therapist. The meetings were informal, with the therapist presiding, and virtually representing the father figure to the group.

The groups were chosen because of some common de-

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nominator, such as a group of alcoholics, of immature, inadequate, socially frustrated individuals, or a group showing neurotic fixations. The discussion would revolve around any of the manifest characteristics of the group, and was quite flexible, depending on the interest and suggestions of the members. A definite attempt was made to avoid a didactic approach. The various members of the group would be called upon to express their opinions on such topics as paternal rejection, effect of a broken home on an adolescent, of poverty, of repeated denials and frustrations. Such characteristics as impulsiveness, inability to foresee consequences, the blaming of one's difficulties on others, the role of sex development and sex tensions were discussed, with frequent use of case histories to illustrate and underscore certain behavior problems. At times the group discussion would lag. A fairly ready way to renew enthusiasm consisted in asking the members of the group to write autobiographical sketches with some explanation of their repeated conflict with society. These sketches were unsigned, and the discussion of the case history of a given participant allowed the prisoner in question both to attack or defend his own conduct and life development.

Frequently, members of the group would volunteer to describe their life histories. The individuals in the group were encouraged to verbalize their fears and disappointments, their pet phobias, and need for aggressiveness. The mere discovery that these exploits were socially sanctioned within the group released some of the hold or hypnotic influence that these inner ruminations caused. To hear members of the group explain the influence of their earlier upbringing, the frustrations of their adolescence, the rejection by their near ones, released greatly the insecurity, allowed a means of detachment from their antisocial pattern and gave the members of the group assurance and confidence. Their lot in life was no more an isolated one. The need of identifying themselves with the outcasts, of seeking favors (or notoriety) with the outlaws, was no longer an imperative one. They found social recognition by the discovery that what ailed them was also

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manifest in the group, that their pitfalls were common to others, and hence the need for compensation or identification did not have to be limited to the luckless groups within confinement.

The rapport and understanding which was gained helped the therapist better to direct the inmate's adjustment, to further plans that would cement more securely the rehabilitation of the inmate into a useful, socially competent individual. The ability to supplement individual guidance to these group sessions helped to give better insight and thus strengthened the will to conform, to sublimate, and to grasp normal mechanisms of living.

The recent work by Jones describes the utilization of psychodrama in focusing and projecting the ailment of a neurotic group to the surface, and thus releasing existing conflicts³. The dramatizations of social or personal problems allowed the patient to see his problems clearly, and enabled him to deal with these problems himself. The plays centered around mental difficulties, parent-child relationship, and education. Jones believes that the dramatization of problems which are of social significance is most impressive when acted out in the presence of a group of people. The individual can contrast his reaction with those of the group. This technique is in line with Schilder's belief that the individual should bring forward his experience for the sake of helping himself and of helping others, and that the intent of group therapy is to give vent to concrete situations which had a definite traumatic effect on the life of the individual⁶. The painful significance of many conflicts or problems loses its poignancy when the patient or inmate discovers that he has them in common with many other people. The mere installation of a knowledge and respect for normal adult development often counter-balances any arrested infantile, immature attitude towards recognized social goals.

Psycho-drama has been used extensively in the rehabilitation of mental patients⁴. A similar application of visual and dramatic material before a prison group would give encourag-

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ing results. The dramatization of a court with its attendant staff of social workers, physicians, parole officers, welfare officials; the acting out, by prisoners, of the various roles and situations which confronted them in life; the visualization of the workings and rationalization of the treatment and destiny which was finally theirs; all this would allow the inmates to relieve their submerged conflicts and frustrations. It would release grudges and misgivings, would provide a better grasp of social values, and would increase the social motivation.

If the function of a prison is not only to chastise but also to create an atmosphere and a setting where the inmate learns to live again as an adult, the participation and keen awareness of the personnel in the measures outlined above is essential. The basic requirements for the success of a program of rehabilitation of prisoners are: 1. The education of the personnel, from warden to guard, in principles of mental hygiene; 2. The development of a spirit of aid and understanding of the prisoners; 3. The cultivation of adult concepts of behavior as well as the actual practice of these concepts in the daily contacts with prisoners.

Summary: The psychiatrist's role is to maintain the prisoner's will and ability to carry on in confinement and to bolster and develop his social motivation. Individual psychotherapy eases the inmate through periods of emotional stress, without letting him escape entirely into a state of dependency. Group psychotherapy helps to develop adult social patterns. The possibility of manipulating and developing adult patterns of behavior among a prison population is a challenge few can bypass once the significance of this task has been accepted.

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GROUP TREATMENT IN REHABILITATION OF OFFENDERS

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Group psychotherapy has been practised in the United States for over forty years. In the last ten years, it has been used in many psychiatric hospitals and in institutions and clinics caring for juvenile delinquents. Its value in the treatment of psychoneuroses, mild psychoses, war neuroses and emotional problems of children and adolescents is now widely accepted. The use of group therapy techniques in prisons, however, is almost non-existent.

In this article the author will give a brief historical survey of group psychotherapy, will discuss the theoretical considerations behind the various techniques employed, will describe his own experiences using group therapy procedures with delinquent adolescent boys, and will endeavor to show the group psychotherapy can be used effectively with old offenders.

A. Historical Survey

Harris³¹ and Bierer⁷ have described the pioneer work in group therapy by Camus and Pagniez¹⁶ in 1904, by Pratt⁴⁵ in 1905, by Emerson²⁶ in 1908, by Marsh^{41,42} in 1912 to 1914, by Lazell³⁶ in 1919 and 1920, by Brauchle¹² in 1927 and by Ozertsovsky⁴⁴ in 1927. Camus and Pagniez, pupils of Dérjine, observed that psychoneurotics treated in the Salle Pinel of the Salpêtrière, showed greater improvement than did those treated in private rooms. In 1905 Pratt held meetings in Boston to treat tuberculous patients who remained in their homes. Marsh did group psychotherapy in 1912-1914 and later in Worcester State Hospital. Emerson used class methods with undernourished children. Lazell, working with Dr. W. A. White at St. Elizabeth's Hospital in Washington, D. C., attempted a lecture method with mixed groups of psychoneurotic

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and psychotic patients. He continued this work for several years⁸⁷ with schizophrenic patients.

Lazell enumerated advantages of group treatment as follows:

1. The patient is socialized with reference to the fear of death and the sexual problem and feels that there are so many others in the same condition as himself that he cannot be so bad.

2. The fear of the analyst as a person is removed.

3. It was found that many patients apparently inaccessible heard and retained much of the material.

4. Many patients develop a positive transference and later ask for individual assistance.

5. The patients discuss lectures with each other.

Lazell discussed problems such as fear of death, conflicts, infantile wish fulfillments, explanation of common hallucinations, masturbation, self-love, homosexuality, inferiority and its causes, day dreaming, etc.

Brauchle used mass hypnosis and mass suggestion. Ozertovsky, working in Russia, utilized class method in treating obsessive neurotics.

Pratt⁴⁶ in 1930 began a "*Thought Control Class*" in Boston Dispensary to treat patients who had many physical complaints for which no organic basis could be found. He used a combination of lectures, plus having patients describe their problems and cures before other patients. Each newcomer was assigned an old member who told of help he had received. Pratt stated: "No statements of a physician are half as convincing as those coming from the mouths of patients who have recovered . . . The appeal is to emotions rather than to reason . . . It is evident that the nature of psychological laws is such that the group method as organized possesses certain elements that act powerfully in energizing helpful emotions and these emotions are transmuted into action with the result that the mental and physical health has often quickly improved." He treated 700 cases in three years and reported considerable benefits to the patients.

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During the 1930's many articles were published dealing with the group treatment of neurotic and psychotic patients. Wender⁶³ in 1935 reported to the New York Neurological Society his experience with group therapy for six years in a private mental hospital caring for mild mental patients and psychoneurotics. In another paper a few years later⁶⁴ he described alterations in his technique of group therapy. Wender stressed that the technique he used was intramural in contrast to the extra-mural group analysis described by Trigant Burrow^{14,15} and amplified by Syz⁶². Wender treated six to eight patients of the same sex in a group. The session began with lecture material, with a description of instinctual drives, conscious and unconscious elements, significance of dreams, early infantile traumata, reaction formations, repressions, rationalizations, etc. The patients then describe their own symptoms. They discuss dreams, etc. Wender stated that he believed the dynamics operating in group therapy were: (1) Intellectualization, (2) Patient to Patient transference, (3) Catharsis-in-the-Family, (4) Group Interaction.

Schilder^{53,54} treated patients with severe neurosis by a group method using psychanalytical techniques. The basis of the treatment was a written report of the patient about his past life and his relationships to others. Dream interpretation and free association were utilized. Among basic problems discussed in groups were: (1) body and beauty; (2) health, strength, efficiency, superiority and inferiority in a physical sense; (3) aggressiveness and submission; (4) masculinity and femininity; (5) the relationship between sex and love; (6) the expectation for the future; and (7) the meaning of death.

In his book, *Psychotherapy*, Schilder⁵³ discussed in more detail his use of group psychotherapy and gave the questionnaires he utilized. The questionnaires not only asked for memories, phantasies and associations, but also for opinions and convictions. In an earlier publication, Schilder⁵² discussed the analysis of ideologies as one aspect of group treatment. He described ideologies as: "Systems of ideas and connotations which human beings build up in order to have a better orien-

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tation for their actions. These systems are fully conscious thoughts which mostly carry with them a large amount of emotions. Individuals usually believe that their ideologies are the result of poor reasoning but astonishingly often do not care to find out why these ideologies are so convincing to themselves. Their belief in their ideologies is usually very firm and the ideologies are often not so very different from religious beliefs with which they share the high degree of inner evidence, very often in contrast to the scarcity of empirical proof."

Schilder⁵³ pointed out that group treatment played an important role in religious movements, indicating how the Oxford movement (Buchmanism) utilized public confession. Similarly group therapy in treatment of alcoholics is utilized in Alcoholics Anonymous⁴.

Group therapy in treatment of essential hypertension has been described by Buck¹³ in 1937. Within the last five years many articles and books dealing with group therapy procedures have been published. Among these are the writing of Jacobson³², Moreno⁴³, Bierer^{2,25}, Hadden^{29,30}, Blackman¹⁰, Rhoades⁴⁷, Low³⁸, Axelrod, et al.³, Amster², Redl⁴⁸, Durkin, et al.²⁵ and Lowrey³⁹. These authors describe group techniques in the treatment of mothers of disturbed children, ex-state hospital patients, problems of grammar school children, clinic and hospital cases, etc. Low³⁸ has organized an association of former mental patients and their relatives. He gives lectures to them and has the audience discuss their various problems.

Bierer^{7,8} describes use of social clubs in treatment of mental hospital patients and discharged patients. He reports the use of "situational" treatment, "class" treatment and "collective" treatment.

Ex-patients of Dr. Louis Wender have organized the *Wender Welfare League*. They meet once a month, have lectures, social gatherings, etc. They publish a magazine, "The Herald"⁶⁵. This organization has been in existence since January, 1935. One of its functions is "to erase from the public

mind the idea of stigma that still seems to be associated with mental or nervous illness."

Many articles have been published dealing with group therapy in the *military service*. Among the recent papers are those of: Shaskan and Josesch⁵⁶, Rome^{50,51}, Schwartz⁵⁵, Jones³⁵, Bion and Rickman⁹, Blain¹¹ and Sherman⁵⁷. Both Rome⁵⁰ and Schwartz⁵⁵ describe the use of audio-visual aids—motion pictures—as useful adjuncts to group treatment and training. Deconditioning to sights and sounds of war—either as preparations for the future or for analysis of past traumatic experiences—are possible in this way.

Among the authors describing group therapy techniques with *juvenile delinquents* are: Bender⁴, Slavson^{58,59,60,61}, Redl⁴⁷, Gabriel^{27,28}, Jenkins³³, Lowrey, et al.⁴⁰.

Bender's work is with neurotic, psychotic and delinquent children under the age of twelve who are observed and treated in Bellevue Psychiatric Hospital. She describes the use of puppets, music, art and group discussions. Slavson and Gabriel work with non-institutionalized neurotic and delinquent children seen at the New York Jewish Board of Guardians. Jenkins' paper deals with the treatment of delinquent boys at the New York Training School for Boys at Warwick, New York.

B. *Theoretical Considerations*

The chief basis for group therapy is that we are social beings, living in social units. Those who show psychopathic behavior, neurotic disturbances, and psychotic manifestations have broken away from the discipline of the group; group therapy attempts to resocialize such individuals. Another practical reason for group treatment is that one therapist can treat many patients at the same time.

The author has already mentioned some of the theoretical benefits from group psychotherapy as described by Lazell³⁶, Wender⁶³, Schilder^{53,54}. Wender⁶⁴ writes as follows: "The premise of group psychotherapy is that the human individual is a "group animal", seeking a satisfactory niche in his social setting; that he is a social product, whose inhibitions and re-

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pressions are motivated by the mores of the group; that difficulties in adjustment and failure to express his emotional troubles are the result of his inability to face the group and to find his place in it. He must repress his thinking and adapt to the demands of a complex group, and his failure to achieve this adaptation produces a neurosis or a psychosis. Place this individual who has failed in the more complex setting into a small group which is friendly to him and which is composed of others suffering from allied disturbances, and he will become enabled, when he learns to understand the problems of the others—to associate himself with them, to release his aggressive tendencies, his hates, his loves and his wishes, without accompanying sense of guilt. By working out his difficulties and achieving adjustment in the small group, he becomes able to face the large group (the world) and to handle his emotional problems, social or other, on a normal basis.”

Harris³¹ treated fifteen to forty patients at a time in the Boston Dispensary. These patients had psychosomatic problems. He stated that the principles of group therapy involved were:

1. Loss of self consciousness by:
 - (a) Group association demanding change from an introvertive to an extrovertive attitude.
 - (b) Desire for approval of the leader, promoting a spirit of rivalry.
 - (c) Identification of patient with the leader.
 - (d) Realization that others have like problems.
 - (e) Increase in sense of importance from promotion by faithful attendance and successful readjustment.
 - (f) Appeal to immature emotional side of the patient's nature.
 - (g) Establishment of goal in life, that is, good emotional habits.
2. Sthenic Suggestion to whole group by:
 - (a) Reading progress slips.

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- (b) Testimony of members who adjusted themselves to their problems.
- (c) Informal talk following relaxation when receptivity is at a maximum.
- 3. Establishment of rapport with leader by:
 - (a) Roll call.
 - (b) Enthusiasm of readjusted members for leader.
 - (c) Occasional personal chats with leader following meeting.
- 4. Reinforcement of all factors operative by:
 - (a) Heightened suggestibility of group.
 - (b) Removal of extraneous stimuli through relaxation.
 - (c) Constant repetition of chief thought chosen for the particular class session.
- 5. Friendly relations established among members, especially valuable for those with limited social opportunities.

C. Group Therapy of Adolescent Delinquents in Bellevue Hospital

The adolescent ward of Bellevue Hospital has been functioning since 1937. Many papers dealing with the organization, types of cases, various forms of treatment, and results of treatment have been published^{18,19,20,34,17,23,24,21,22}

The ward cares for boys ranging in age from twelve to sixteen, the majority of whom have been sent to us as juvenile delinquents from the Children's Courts of New York City.

The charges vary from small offenses such as truancy and quarrelsomeness to the more serious delinquencies such as stealing, fire-setting, rape, and murder. The majority of the court cases on the ward have been given one or more opportunities on probation before being sent to us, so the cases represent the most serious type of juvenile offenders. Before 1942 we usually had fifty to sixty patients on the ward at one time but now, due to lack of personnel, we have limited our ward census to twenty-five.

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particular questions to ask. When a question is asked the psychiatrist inquires whether or not another boy can answer the question. If no one volunteers, each is asked what his information is regarding the question. In this manner, considerable data concerning adolescent sexual misconceptions has been collected.

If no question is asked, the physician introduces a topic, usually that of masturbation. This is deliberately chosen because we have learned most of the adolescents have unresolved conflicts associated with this practice. If no one is able to give the correct information the psychiatrist presents the solution. If this has to be done, the boys are asked to restate in their own words what the physician has said, because we learned that the patients often failed to understand exactly what was said. When they hear correct explanations from one of their fellows, and it is confirmed but not forced upon them by the physician, they are better able to accept it as new and true knowledge.

The boys are encouraged to speak without restriction or self-criticism. They use the terminology with which they are familiar and they are quite at ease as soon as they become aware that the psychiatrist offers no censure.

The average conference lasts 45 to 60 minutes. Frequent topics are masturbation, impregnation, nature of ejaculation and semen, frequency of coitus consistent with health, gonorrhea and syphilis and their modes of contagion, sexual perversions, etc.

Not uncommonly we are able to detect by a particular boy's question, even if not by his actual statements, that he is either sexually preoccupied, homosexually inclined, or possibly even psychotic.

We believe this technique to be diagnostic, therapeutic, and pedagogic. For those interested in more details of this technique with a verbatim representative excerpt of a group discussion, we refer you to the paper published by Drs. Strauss, Vogel, and myself²⁴.

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2. *Conferences on Aggression, Medical Diseases, etc.:* Similar conferences to that described above are used in discussing problems of aggression, discipline, and significance of emotional disturbances. Analysis of ideologies (Schilder⁵²) are done. Free discussion about signs and symptoms of physical diseases are carried out.

3. *Art Techniques:* The use of art classes in Bellevue Hospital as one form of group therapy has been described by Bender⁵ and by myself^{20,21}.

Usually four to eight adolescents are sent to the art class at a time. When the W.P.A. was functioning, we had an art teacher sent to us from the Federal Art Project. At present student nurses supervise this form of treatment. Because of a restricted budget we do not use finger paints but we use water colors, crayons, and pencils. A special room is designed for art work and each group spends 30 to 60 minutes a day there. In this way most of the patients have an opportunity to participate in the project daily.

It is our belief that the art instructor should encourage the patient to draw whatever he wishes. The teacher should not suggest topics and should inform the patient he is free to draw anything. The teacher's attitude should be tolerant, not critical. This attitude is quite important as children often wish to draw obscene or sadistic scenes and may have been prevented from drawing such pictures in their regular school work. In general the patients work in groups and the children encourage, criticize, and make suggestions to each other. The paintings are exhibited in the art class, in hallways, in physicians' offices, etc. The greater the diversity of subject matter on display, the more encouraged will be the patient to draw the things that have special significance for him. This type of art work has a close relationship to the free association and the play technique utilized by psychoanalysts in the psychotherapy of children.

As in the other group activities, the patients feel free to express through art their problems, fears, and needs in the permissive atmosphere of the group. After they paint they are

asked to tell why they selected the particular subject matter; they are encouraged to make up a story about the persons or scenes depicted. They are encouraged in the group setting to discuss not only the art work but any other subject that arises, such as personality of staff members, the anti-social conduct of other patients, their own aggressive tendencies toward teachers, policemen, physicians, etc. This working in groups helps the patients to get rid of a great deal of their aggressiveness through the paintings plus the verbal catharsis that follows.

4. *Dramatic Project*: Bender and Woltmann⁶ have used puppet shows in the treatment of younger children at Bellevue Hospital. It was the authors' belief that a dramatic project in which patients could write and act in their own plays would have more appeal to older patients than would puppet shows. With the aid of the Hospital Recreational Unit of the Works Progress Administration we instituted a dramatic project, as one form of group therapy, in 1937. At the present time, this project is still being used with supervision of the nursing instructor (Mr. E. Vargas) and the student nurses on the adolescent ward.

Arrangements were made so that each adolescent would spend a certain amount of time every weekday in writing or rehearsing for a play. Occasionally we suggest to the dramatic coach that one or more shy boys be put in certain plays, hoping they may benefit from acting before others. In most instances however, we permit the authors to select their own casts from their fellow patients. If this technique fails, the play is read aloud and the boys decide which roles they wish to play. Whenever feasible, we try to produce a play while the author is still in the hospital. This is done so that the dramatist will receive due recognition for his work by the other boys and by the staff. Moreover, other boys are then encouraged to write plays.

Once a week a play is presented on the ward before other patients and the staff. The boys in the play, with the aid of the art project workers and the occupational therapist, make

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whatever properties and scenery are necessary. Sheets, blankets, and operating room gowns, discarded dresses of nurses, white coats of internes, etc. are utilized when costumes are needed.

The children are not instructed as to the type of plays they should write, but are told merely to write about anything that interests them. The plays are usually short and have many scenes. At times the boys adapt plays from movies they have seen or from books or short stories they have read; the majority of the plays deal with crime, school activities, and hospital experiences. After the play is presented, all of the ward patients are gathered in one large room and the psychiatrist then discusses the play with them. It is our policy to congratulate the author and actors and then ask how the author happened to write this play; he is asked if he believes the play to be true to life. The psychiatrist then asks if any other patient would change the behavior of any of the characters if he were writing the play and if they believe the scenes which they witnessed could happen in real life. The actors are told to describe their own emotions while performing, asked if they felt self-conscious or if they felt themselves temporarily to be the characters they were portraying.

Using such questions as a beginning, we permit the general trend of the discussion to go into whatever channel the patients direct it. We have learned that in every such discussion the children will bring up ideas on many diverse subjects such as hospital rules, personality problems of staff and other patients, food, children's court, judges and probation officers, sex, general problems of delinquency, etc.

After the interview (which lasts 60 to 90 minutes), the psychiatrist has a much better idea about specific problems confronting specific patients. If the discussion has revealed that five to ten of the boys are preoccupied with problems of sibling rivalry, school difficulties, problems of aggressiveness, sexual problems, etc., then the smaller group is later interviewed, concentrating on the specific difficulty.

The author is usually questioned in some detail as to how

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he happened to write the play and attempts are made to correlate the boy's problem with his dramatic production.

The mechanism of identification and projection are clearly seen in the plays written and in the selection of parts in the plays by the boys themselves. We have observed repeatedly that effeminate boys beg for the female roles; the aggressive boys wish to portray gangsters, while the schizoid boys wish to represent such persons as teachers, nurses, judges, attorneys, or physicians.

The patients find outlet for their aggression in acting in plays and in participating freely in the discussion afterwards. Often through the plays the patients act out their problems of sibling rivalry, feelings of parental rejection, etc.

Atonement of guilt is made possible in the plays by characters being killed, imprisoned, or tortured. "Third Degree" scenes occur frequently in these plays as do scenes of capital punishment. As a result of free discussion of previously forbidden or unmentioned topics, the adolescents, by hearing others express their views concerning hate, fear, sadness, and destruction, and by acting out their castration fears and sexual problems in the plays, lose, to a great extent, their fear and anxiety. It is our belief that it is not sufficient that the play shows atonement of guilt by torture, imprisonment, or death. The players must be made to understand that the severity of the atonement is merely another disguise for aggressive tendencies. This dramatic technique is not merely a method of occupying children or giving them superficial amusement, but it is a method of group catharsis by play acting¹⁹.

D. Use of Group Psychotherapy With Offenders

I have already described various group therapy techniques which have been utilized successfully in the treatment of juvenile delinquents in Bellevue Hospital. In my opinion similar techniques can be used with older offenders, with some modification necessary to fit the particular settings of the incarcerated individuals.

It has been frequently stated that older delinquents will

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not talk, that they are on their guard, etc. Similar statements have been made about adolescents. I have observed repeatedly at the beginning of a group conference that some of the bigger and more aggressive boys will warn others not to talk because a stenographer is taking notes. Most individuals, however, delight in talking, and we have learned that those who started out by warning others not to talk soon participate actively and assume leadership in discussions just as they assume leadership in aggressive or destructive behavior. The use of group therapy conferences with adult mental patients and war neurosis cases reveals that most adults have distorted ideas about symptoms of mental and physical disease, have bizarre ideologies about most psychological concepts, and they, in my opinion, will be eager for group therapy.

E. Discussion

In this paper I have described the various types of group psychotherapy used in the treatment of neurotics, psychotics, and juvenile delinquents. I have pointed out the various theories presented by many authors concerning the efficacy of such treatment.

I wish to stress, as I have done elsewhere¹⁹, that in dealing with offenders or with neurotics or psychotics, the most important thing is that the patient be individually understood and that he should be cared for as an individual. The individual interviews, in my opinion, are the most important part of treatment in hospitals or correctional institutions. Whatever has happened in various group activities should be summarized and explained in its deeper aspects in the individual interview. It is possible in this way to exemplify for the patient his own problems in the problems he sees in others and which he can recognize more readily in others than in himself. The problems of leadership, organization, and adaptation appear in varied aspects and help the patient more freely to associate his own experiences in relation to what he has observed on the ward or dormitory. He learns, also, that his aggressiveness and destructiveness are closely connected with specific diffi-

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culties in adaptation, and, as a result, his behavior becomes more socialized. He learns, furthermore, that when the ward or institutional discipline forces him into restrictions, these restrictions are socially necessary. In addition, he learns tolerance toward the problems and difficulties of others and comes to understand that many of his aggressive and antisocial impulses are merely a screen behind which he tries to hide his social and sexual shortcomings from himself and others.

F. Conclusions

In this paper the author describes various types of group psychotherapy techniques which have been used to treat neurotics, psychotics, and delinquents. He has described in some detail his own experiences using art, drama, and group conferences in treating adolescent delinquents. He has pointed out the relationship of group to individual psychotherapy. He believes that similar group psychotherapeutic approaches can be used successfully in dealing with older offenders.

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BRIEF CLINICAL PSYCHOTHERAPY BASED ON CONSIDERATION OF PUBERTY

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The importance of brief psychotherapy in the work of the clinician, the social worker, and those who deal with neurotics professionally, is now widely recognized. The ideal approach to such work would quickly provide sufficient information for both the psychotherapist and the patient. The latter should be shown that the "abnormality" of his behavior and aims is due to some automatisms which control his life, decisions, and actions; that he acts according to patterns which can be understood and perhaps altered; that not Fate but his reactions to his past and environment determine his personality. The therapist should inform himself about his patient's amenability to psychotherapy, the strength and age of the patient's neurotic conflicts, and his ability to gain insight into underlying mechanisms. In many cases, investigation of puberty reveals the answers to these questions in abundance, and furnishes the material on which psychotherapy can be based.

F. Alexander criticized proposals for changes in the psychoanalytic technique on the grounds that the authors merely emphasize the importance or helpfulness of one particular mechanism, and therefore tend to neglect other important aspects of neurosis¹. The following proposal, offered as an expedient means of arriving at the unconscious and making it accessible to therapy, stresses no mechanism to the exclusion of others. It is my experience that anomalies of puberty revive old conflicts and reveal their attempted solution in the manifestation of ephemeral psychosomatic symptoms, new in their expression but old as far as causes are concerned. If it is possible to focus a neurotic woman's attention on features of her puberty, she may thereby be faced with an old emotional experience which acted on her like a psychic trauma.

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It goes without saying that this procedure should not be applied indiscriminately. There are numerous patients of whom the most careful investigation fails to yield results. This may be the consequence of a total amnesia for this epoch, in which case we have to decide whether to look for another approach to the unconscious or to remove the amnesia.

In other patients, a seemingly normal puberty is recorded and in the initial interviews we are unable to detect those distortions which arouse our suspicions and which betray neurosis. Finally, a latent psychosis may obscure the features of this epoch; however, our insight into this dependency is incomplete. E. Bleuler is quoted by Meyer-Ruegg as saying that in schizophrenia, dysmenorrhea is completely absent⁵. However, my experience with this mental deviation is too narrow to allow comment on such a statement.

I feel it appropriate to state the limitations of my work. I approach psychotherapy from gynecology, and therefore am most interested in gynecological symptoms. The majority of my clientele, in hospitals as well as in private practice, is female. Therefore I am in no position to extend my proposals to male patients. In a few cases I have been able to apply the procedure successfully to men; whereas with others nothing could be gained. H. F. Dunbar and her co-workers excluded Negroes from their psychosomatic studies because they found the majority to be poor observers of themselves³. In my experience it has been relatively simple to win the cooperation of colored patients when discussing features of their puberty.

It must be stressed again that the proposals to be discussed aim merely at shortening the sometimes prolonged initial phase of psychotherapy. The neurotic scotoma of the prospective patient prevents his perceiving the energies of his unconscious. He feels relieved if he is shown that the same energies molded his puberty which are now manifest in his neurotic symptoms or character traits.

NORM OF PUBERTY

The biological aim of puberty is to change the individual into the state of maturity, enabling him to perform his duties

toward his species, to preserve and propagate his kind. The bodily changes are associated with a sharp increase of instinctual drives which facilitate the fulfilment of the all-important biological object. In human beings, a physiological neurosis is manifested during puberty, due to the impact of endocrine and emotional changes. These new endopsychic tensions alienate an individual from his environment, and this emotional estrangement is the stronger the more the individual is prone to harbor hostile feelings toward his surroundings.

The chief manifestation of puberty is the drive for independence, which is generally expressed by an aggressive attitude, more or less explosive reactions, intolerance, nostalgia, and by the most contradictory emotions, desires, and drives. The feeling that something strange is going on within the body, that an epoch is finished and a new one in the making, is likely to bring old conflicts to the conscious. These features of puberty impress us as apparently being neurotic. However, since they are common to an overwhelming majority of human beings, their abnormality is doubtful. This epoch of revolt, of lack of poise, etc., is usually outgrown, and then recollections of it are poor. The longer its duration, the more deeply is the memory impressed by, or burdened with, recollections of this epoch.

Of paramount importance is the age at which the bodily changes occur. There is much to support the belief that hereditary factors determine the site and time of the prepubertal changes, as is the case with the fertility. Studies of the menopause furnish convincing evidence of the importance of hereditary factors.

During puberty the psyche reacts to the additional burden by mobilizing reaction patterns dating from childhood. Freud compared late puberty with a new edition of the Oedipus situation⁴. Helene Deutsch assumed that marked bisexual tendencies are characteristic of early puberty, and strong heterosexual tendencies prevail during the later puberty².

DISTURBED PUBERTY

It may suffice to mention only a few of the numerous exogenous factors which upset this developmental state. Malnutrition is supposed to delay maturity, but there is hardly one malnourished individual who is not exposed to other adverse factors closely connected with this deficiency. If we remember that lack of proper food speeds up tuberculous processes, which in turn precipitate or delay maturity according to the nature, site, and severity of the disease, we realize the many complexities of this stage. Schopenhauer's observation that girls mature in towns earlier than in the country has been found correct by many investigators. It is more than a romantic belief that the blossoms in the dust bloom earlier and shorter.

The influence of exogenous factors varies according to the psychic reactions. Many observations in the literature prove the delaying effect of emotions upon the menarche. Norman Reider observed the onset of the period in an emotionally inhibited girl⁷. F. Mohr recorded the case of a girl in whom pubescence was delayed for ten years by a series of stormy emotions⁸. Under psychotherapy, the delayed development went forward in a few months: menstruation set in, bust developed, and a peculiar hairiness of the chin disappeared.

Delayed Menarche. The important exogenous factors impress themselves upon the girl's psyche. It would, nevertheless, be unwise to minimize the former and to limit our investigation exclusively to the psychic reactions. In brief psychotherapy it is favorable to lessen the guilt feelings merely by showing that some of the patient's neurotic (of disadvantageous, even fateful) behavior patterns, from which we hope to free her, originated in her surroundings. One might suspect that a late menarche expresses resentment of womanhood. This may be the consequence of any traumatic experience of her own or someone close to her; or a strong fixation on any

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member of her family. A report might illustrate the dynamics involved.

A forty-three year old colored woman has been treated for almost a year before being referred to psychotherapy. She complains of nervousness, general weakness, and shortness of breath. She was operated on for pyosalpinx eight years prior, and for an ovarian cyst four years prior to psychiatric consultation. Her menses have been weak since the second operation.

Her sickness began at the time when her employer showed the first signs of a menopausal disturbance, about two years after the patient's second operation.

The patient was married twice, but both husbands walked out on her, as did her daughter, whose marriage never ceased to worry the patient. She never failed to express disapproval of her daughter's conduct and tolerance of her husband's vices.

The pregnancy was allegedly uneventful, but the patient is reluctant to discuss its effect on her marriage. As a matter of experience, pregnancies, especially when aborted, exert a baleful influence upon marriages of neurotics. The patient volunteered the information that her menstrual cramps were not changed by her delivery; she had suffered from them since her menarche, at the age of eighteen.

This forty-three year old woman gives an extremely vivid description of her menarche: one night, she was overcome by strange feelings, went to the (outdoor) toilet, returned to her bed, and then discovered her menstrual flow. Convinced that she had sustained some injury to her genitals (in her own words, "I had cut myself on a nail or piece of glass"), she took a candle and went to inspect the toilet. Then, in the middle of the night, she awakened her stepmother, who calmed her down and lessened her fear.

The patient voluntarily furnished the explanation of her behavior: her mother had died in childbirth when the patient was eight or nine years old. Of this catastrophe, the patient gave a fairly exact picture, showing her deep concern

with that happening. She reported that her father married five years after her mother's death, and, surprisingly, that she was deeply devoted to her stepmother, who raised the children with great affection.

It was significant that this woman, raised in a small Negro community in the South, had no inkling of menstruation until her eighteenth year, although she had witnessed her mother's last and fatal delivery ten years prior to her menarche.

Her numerous conversion symptoms led me to suspect that she identified herself with her employer, to whom she assigned the role of her mother. She imitated the menopausal symptoms of her mother image. At first she benefited from the same pills which her employer took. All other drugs affected her in a manner contrary to expectations. Her puberty was dominated by her inability to identify herself with her mother, since to do so might induce her own death. For that reason she avoided menstruation as well as any knowledge of it, and for the same reason she rejected her daughter. This patient's emotional evaluation of onset and end of menstruation is identical.

Premature Puberty. The most striking cases of premature maturation are caused by degenerative processes of endocrine organs. The rarity of this condition, which has hardly been investigated psychologically, obviates our further consideration of it.

According to A. Gesell, who studied two cases, one of whom began to menstruate at the age of three years and seven months, the other at the age of eight years and three months, the psychological features were not impressive at all. In neurotics, however, some traumatic experience may precipitate the menarche; other emotional disturbances may have the same effect. In these cases, meticulous investigation of the menarche shows this dependency. It is arbitrary to assume a certain age as normal for a girl to start her menstrual flow. It has already been mentioned that the most disparate factors determine this event. But disturbances of puberty are not always tied in with the time factor. They might be expressed

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by overemphases on any phase of puberty. The importance of the pubic hair is demonstrated in the following report.

A colored woman, age thirty-eight, suffers from different conversion symptoms. Her menstrual history contains this rather peculiar detail: the only effective means of alleviating her considerable menstrual discomfort is—parting her hair in the middle. She discovered this “ridiculous” but “magically efficient” trick some years after her menarche when, as she combed her hair, she noticed a sudden diminution of her menstrual pain. Further investigation revealed that she had had a strong reaction to the growth of her pubic hair. The pubertal change she had mistaken for a betrayal of or punishment for her earlier sexual activity.

In this connection, reference must be made to compulsive symptoms which revolve around hair. These symptoms may be manifested periodically during a certain part of the menstrual cycle, or they may be detached from the period. They sometimes center closely around the object, hair; but in some cases other objects substitute for hair. In either event, the emotions remain mostly unchanged and nausea is their predominant expression. An observation illustrating the significance of hair—which almost equalled a fetish—is the following: a forty year old white spinster mentioned casually during her treatment that she was unable to dispose of her deceased mother's wig. She kept it in a drawer and moved it from one place to another. Although she was always nauseated by this object, she was unable to assign a proper place to it. This patient showed many reminders of oral eroticism and the most nauseating object to her was hair. In this case, a strong anxiety reaction to the growth of her pubic hair was spontaneously remembered, an expression of her deep hatred of her mother. This emotion determined her life fatefully.

We are sometimes in a position to observe the genesis of genuine taboos connected with menstruation. A patient remarked that for a time she was strongly opposed to shampooing her hair when menstruating. She attributed this objection, from which she was freed after long discussions with

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different authoritative persons, to an early conversation with her girl friends. When she was eleven years old a beautiful blind girl drew the youngsters' attention to her handicap and they sought for an explanation. After long and fruitless discussions, one girl happened to explain this blindness by the fact that she shampooed her hair during menstruation.

The foregoing observations center around the pubic hair as the object. Breasts and hips play as important a role as does pubic hair. A woman of twenty-one, complaining of frigidity and anxiety, had been deeply disturbed when she noticed the growth of her breasts. She used to tie them down with a piece of fabric for fear of being excluded from the boys' play, and, worse, being teased by them if this change became noticeable. Another patient treated for similar symptoms considered her breasts as a mere nuisance during her whole puberty. She was disturbed by their unequal size, but more so because they were an obstacle when she moved her arms.

The manifestations just described are less common than an apprehensive attitude toward the onset of the flow. The example given under the heading, "Delayed Menarche", is almost typical for all neurotic colored patients and, of course, this reaction is by no means restricted to members of this race. With a great monotony the belief of having sustained an injury to the genitals from nails, glass, knives, needles, etc., is reported by our patients. Needless to say, every single detail of such apprehension is worthy of being investigated meticulously.

In the example last mentioned, the conviction that the bleeding would never stop, or that it was fatal, stems from old death wishes which first appeared with the late pregnancy of the mother, or as a reaction to her attempt to stop the little girl's masturbation. Such situations can be used in acquainting a patient with the different phases of the Oedipus situation.

The strong apprehension experienced with the first menstrual flow usually carries over into other menstrual disturb-

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ances, which will be discussed in the next section. As will be shown there, these disturbances can best be understood if their first manifestations are clarified.

A protesting attitude toward the first menstruation is usually well and clearly remembered. At that time protestation against the secondary sex characteristic is mostly repressed. It seems as if the memory were capable of preserving only one feature of rejection, and therefore suppresses other forms of it together with their causes. It must be stressed again that the reports of puberty must be analyzed as carefully as screen-memories from childhood.

The psychologist is well acquainted with the phenomenon that the same trend may manifest itself in opposite reactions. It is not the rejection or the submissive acceptance of the menarche that counts, but the overdoing and exaggeration of the reactions to this decisive event. Too cheerful an attitude is as significant as too violent a rejection. It is to be expected that probing into the past will reveal a phase in which the girl protested against one sign of maturity or another.

MENSTRUAL ANOMALIES

Strongest emphasis must be put on the circumstance that menstrual disturbances may be symptomatic of serious clinical disorders. If a patient is suffering from one of the menstrual disturbances to be discussed later, we must, of course, exclude a pathology before we consider its psychogenesis.

This presentation shows only the most common symptoms; the aim to be complete and to enumerate all anomalies of menstruation is beyond the scope of this article. It seems, nevertheless, imperative to mention a few other conditions and diseases of which the syndromes to be discussed are symptomatic. Amenorrhea is known to be due to many physiological conditions, such as pregnancy and lactation; consuming diseases such as carcinosis and tuberculosis; it accompanies many endocrine conditions, and it is well to keep in mind that some diseases of the pituitary, thyroid, and adrenal glands begin with amenorrhea, as well as with a phase which appears to be

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a neurosis. Other diseases may provoke any other syndrome of the genital sphere. In dealing with these syndromes, medical advice must be sought prior to the psychological examination.

In the psychiatric and gynecological literature innumerable observations prove a close dependency of menstrual disturbances upon emotional derangements. The coincidence of these syndromes with sexual abnormalities is rather common. The physiology of these manifestations, however, is far from being understood. That may be the consequence of our present approach to physiology, which is based almost entirely upon observations of experimental animals. It is more than doubtful that the laboratory will furnish a biological insight, because the emotional milieu responsible for these syndromes can never be established in an experiment.

The absence of a generally accepted theoretical explanation, however, should not prevent the psychologist from making the utmost use of these manifestations in his work. It will be shown that these disturbances are indicative of emotional derangements. However, this statement leaves open the etiology of these syndromes. We do not have to concern ourselves with whether an amenorrhea, dysmenorrhea, etc., is caused by some traumatic experience, by some kind of endocrine anomaly, or any disturbance localized in the autonomous nervous system. We only investigated these manifestations *symptomatically*, i. e., we try to find out whether or not some tangible emotional conflict may have accompanied these genital manifestations.

Secondary Functional Amenorrhea. We define this syndrome as the suppression of the menstrual flow after its establishment, in the absence of any gross pathology during the reproductive period. It is generally accepted that in amenorrhea several menstrual periods are absent. If only one period is missed, we speak of suppression of menses. Retention of menses applies to a condition where the flow is produced but prevented by some anatomic changes from being excreted.

In this paper, emphasis is put on the term "functional". All textbooks mention sudden shocks, excitement, or other

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psychic phenomena as causative factors of amenorrhea. Usually, change of climate is added. Immigrants show this symptom frequently; my own studies have furnished me with some evidence that menstruation reacts more to the psychic elements of the new surroundings than to its physical aspects.

Here we are concerned with the psychic mechanisms which may originate the syndrome. Usually the history of puberty presents us with some index; some conversion or, less frequently, obsessional symptoms are usually reported, and the patient shows a striking lack of adjustment to reality, his family, or occupation.

Prognostically speaking, this syndrome seems to give a gloomy outlook. My experience with it is rather limited, but the few characteristic cases I happened to have studied impressed me with this prospect. Even in cases where the symptom has subsided spontaneously, its paramount symbolism—self-destruction—never ceased to dominate a patient's existence. Because of these facts, in treatment we must use an extremely cautious approach to the underlying mechanisms.

Another point of importance must be mentioned. Some patients with a history of amenorrhea periodically manifest meno-metrorrhagias. In one of my observations an amenorrhea of several months followed an attempted rape. Subsequently the patient neglected herself, ate sweets compulsively, and became extremely fat. She then attached herself to a mother-image, a female artist, who tried to seduce the girl after getting her drunk. Her menstrual flow set in again then, but it was irregular and profuse for some time. This patient's periods reflected her frame of mind. Her anticipations prior to the attempted seduction by the man let her fall easy prey to his wishes. She mistook the stranger for an old acquaintance of her family and expected him to bring some gifts from home. These anticipations betray the direction and content of her sexuality, which was dominated by unconscious incest wishes. The amenorrhea expressed her desire for punishment for the unconscious aims of her sex life. In her unconscious she misunderstood the attempt to be an actual

achievement, believed herself to be pregnant, and therefore associated herself with the mother-image. When she was confronted with sex again, she was forced to assume her prior status but was unable to accept it entirely.

Dysmenorrhea. By dysmenorrhea is meant a state of distress which accompanies menstruation. In a recent paper I tried to define this common symptom and to show its importance for diagnosis and treatment of neurosis generally, and of certain gynecological symptoms especially⁸. Its incidence is extremely high; reliable figures, however, have not been published. I am of the opinion that its incidence in New York is about eighty percent among colored, and seventy to seventy-five percent among white women, according to a superficial investigation of several hundred pregnant women in Sydenham Hospital.

The etiology of this syndrome has been a moot question, but there is an increasing number of endocrinologists who believe that neurotic mechanisms originate and maintain it among those patients in whom any pathology (old or acute inflammation, infantilism, tumor, etc.) is absent. A carefully elucidated history furnishes sufficient material to indicate or exclude the psychogenesis of menstrual pain.

In a full-fledged case, all menstruations are accompanied by more or less sensible distress. In the majority of our patients the pain is perceived in the uterine region, but it may extend to neighboring organs, affecting bladder or rectum. Pain or dysfunction may be manifested in almost every organ, the most common ones being the digestive system (stomach neurosis, nervous vomiting, anorexia, or cravings), the head (cephalea, migraine, etc.), the heart (palpitations, heart neurosis). These manifestations may either accompany or substitute for menstrual pains.

Rarely, the sexual sphere is afflicted. In these cases, however, the most impressive observations can be obtained, and their study reveals the impact exerted by the menstruation on the personality. We can observe a complete change of the sexual aims (homosexual trends, compulsive masturbation,

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heterosexual desires in homosexuals), or a striking increase or diminution of the sexual libido (promiscuity, nymphomania, abhorrence of sex).

Even in the severest cases of dysmenorrhea, any variation in the intensity of the menstrual distress is mentioned spontaneously. It is the patient who offers an explanation of this change. She was either elated by some flattering, self-assuring event—and the pain of the ensuing flow diminished or disappeared; or some catastrophic event injured her pride—and the next menstruation was accompanied by severe, even agonizing pains. The proof of this dependency is of utmost importance in our therapeutic endeavor and might win a reluctant and hesitant patient's cooperation.

A superficial analysis of the symptom clarifies the most decisive fixations which support other trends of the patient's neurosis. The conversion symptom "dysmenorrhea", expresses the most important conflicts.

The following report is remarkable for several reasons: first, the patient could be followed up for a great length of time; second, in her dysmenorrhea all the dynamics of her neurosis were reflected; third, the time spent on relieving her menstrual neurosis was unusually short; fourth, a cautious interpretation seemingly directed to the dysmenorrhea, and therefore accepted, became the working principle on which she remodeled her entire existence.

An unmarried woman, twenty-seven years old, wanted a gynecological checkup. She gave a history of strong menstrual pain which could be relieved only by morphine. This pain, which she only perceived after awakening, kept her in bed for the first four days of her menstrual flow, which usually lasted for eight days.

She opened the interview spontaneously with a vivid description of her parents' reaction to her menstrual pain and showed strong emotions in connection with this. Her mother constantly insisted on her consulting physicians. Her father usually failed to show any concern about her periodical pains, but, in some instances, he alleviated or relieved her suffering

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completely by pitying her and putting his hand on her forehead. Generally, he was too deeply involved in his own affairs; the girl is sure he was unfaithful to his wife and apparently his conscience burdened him.

The patient continued to report on her sex life. She had relationships with a man, but their desolate financial situation rendered their plans to marry impossible. The patient's skepticism as to this relationship was augmented by the absence of sexual orgasm.

In interpreting this material greatest stress was put on this patient's dependency on her father. With his example in mind she was opposed to marriage, assuming that her fate would be like her mother's. Therefore, she revolted against her femininity, and this stand caused insecurity and indecisiveness. In her female role this rebellion prevented her from achieving the best in any given situation. Her resentment of her father's conduct was based on the unconscious assumption that she was married to him. She therefore expected that all men would behave the way he did. Her dysmenorrhea was further a means of attracting his attention to her, to her mother, and to her family, all of whom were affected by his behavior. This syndrome played an important role in keeping the family together, and the patient therefore never seriously attempted to be relieved of her menstrual distress.

Clarification of the central idea expressed in her dysmenorrhea was followed by far-reaching changes in her life. This patient was followed up for a period of fifteen years. Within the two years following this short psychotherapy she accepted reality by finding a satisfactory business position. She eventually married a congenial man and was successful in her marriage.

This report fails to show the impact of puberty on symptoms and character of this patient. I am of the opinion that it conveys clearly the importance of this genital symptom to the whole personality. In this patient, her genital neurosis expresses the aims of her character anomaly.

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A colored high school girl, nineteen years of age, is referred to Sydenham Hospital because of strong menstrual pain which necessitates rest in bed during the first and sometimes the second day, for periods varying from three hours to two days. Invariably she did not eat on the first day of her menstruation lest she vomit. Another regular feature of her menstruation is urinary frequency. The patient believes that her pain began at the age of sixteen. Her menarche set in when she was thirteen years old. She vividly describes this experience: "When I noticed the blood I was terribly excited because I had never heard a thing of it. I believed I had had an accident, hurt myself, and the bleeding would never stop. If I urinated the bleeding increased. Then I noticed my dress was stained and I believed I had sat down in some dye or perhaps I had swallowed some glass. Finally, I confided in my mother, who told me it would come every month. I was "dreadfully scared."

The next period occurred three years later. The patient is not sure when her menstrual discomfort began, but the second time she reacted not so violently as the first.

The patient was questioned about her family. She has four sisters, two older and two younger ones. Her mother was married three times, and the patient is the oldest daughter of her mother's third marriage. She never conceals her resentment of her mother because of her marital instability and her hostility towards her current husband, an invalid. One older sister is insane, the other married. The mother dominates the lives of her children and the patient desires to leave her environment but is handicapped by a disfigurement, remnants of severe rickets.

Discussing her reaction to her first menstruation, the patient recalled that she must have had some idea about menstruation because she is sure she had noticed blood on her mother's and older sisters' underwear. She added that she always thought it was none of her business—and then she reproduced some recollections of annoyance and even sickness connected with "this dirty business". These remarks showed

the patient's strong protestations against womanhood generally and menstruation especially. Her attitude may have postponed her next period, an assumption expressed by many psychologists as well as gynecologists. It was more than probable that this same attitude was supporting her menstrual discomfort. The patient was shown that she was fighting her real nature, that she identified menstruation with her mother, thereby confusing her enmity with this physiological act.

The patient reported that during the following period she could eat normally, the pains were negligible, and she volunteered that her attitude towards her mother had been improved. She felt less irritated by her mother's behavior and less offended if she gave some order.

Negative Dysmenorrhea. In lieu of a definition, a short consideration may clarify the meaning of the term negative dysmenorrhea. There are numerous, apparently neurotic patients whose symptoms disappear as soon as their menstrual flow begins. We encounter this phenomenon rather frequently among women afflicted with constipation. I have on record a girl complaining of leucorrhea, headache, and restraint and ineffectiveness in her work, who was completely freed of her discomfort and inaptitude when her menstrual flow began.

Since menstruation frees these patients completely from their neurotic disturbances, they never show any discomfort during that time. However, it is not surprising that this situation can be reversed, and dysmenorrhea appear in the patient formerly free of it.

We find that, in cases of negative dysmenorrhea, the patients repress their protestations against maturity; their recollections of puberty are distorted or lacking in significant details. However, they are likely to show a genital symptom in response to any actual "calamitous" event. Investigation usually proves that these patients welcomed the first signs of maturity as a promise of approaching liberation. Their early teens were usually marked by promiscuity and revolt against the family, school, and authority in general, an expression of

their keen desire for independence. They felt called upon to effect great achievements or reformations, although completely lacking serious preparation for such tasks. Their extremism is usually overshadowed by apparently neurotic behavior or character traits, which they attempt to conceal from the interviewer. Further investigation often proves the existence of compulsions, frequently localized in the oral or anal regions. These are expressed in the strict avoidance of certain foods (meat, milk, vegetables, etc.), or specific facilities (automobiles, trains, fountain pens, etc.); or in the lavish acceptance of or complete emotional abrogation of philosophical, economic, religious systems, etc. Analysis of a "simple constipation" may reveal hitherto unexpected aspects of an underlying psychopathy. Sometimes schizophrenic features come to light. In the majority of cases, some genital syndrome comes to the fore, confirming the diagnosis of psychopathy.

The actual cause of these menstrual disturbances is a traumatic genital experience, either pregnancy, venereal disease, or a change in the girl's reaction to cohabitation. An abortion usually exerts a devastating influence on these girls' relationships to their mate, family, or surroundings.

The following observation of a patient of relatively low intelligence may illustrate some of the symptoms usually encountered.

A white woman of thirty-six consulted me for numerous neurotic symptoms, constipation and premenstrual tension being outstanding. All her symptoms disappeared with the onset of her menstrual flow. During menstruation she was able to have regular bowel movements, to tolerate food which otherwise distressed her, to move about town unrestrictedly, and to sleep restfully. In other words, menstruation changed her into an unneurotic, efficient human being.

The history of her constipation furnished enlightening details of her neurosis. As long as she lived in her native country, she suffered with diarrhea, probably the remnant of a tuberculous infection which was first manifested at the age of three. As soon as the patient boarded the boat for this

country, her digestion became normal. Some years later, when the patient involuntarily experienced a clitoric orgasm, constipation set in and gained momentum until finally it became a paramount problem of her existence. Constipation was the forerunner of the numerous other neurotic symptoms which complicated her life.

Recollections of her puberty at first failed to reflect any neurotic features. The girl recalled some homosexual experiences dating from the age of nine. At eleven or twelve she fell in love with a boy, but at the age of thirteen she eliminated sex because she felt obliged to support her family. She became a dressmaker, and a year later her reputation as the dictator of fashion in her small country town was established.

Further probing disclosed that her puberty ended a long period of uncertainty. The patient vividly recalled the trauma of her weaning. One day when she was two and one-half years old, she found her mother's breasts covered with a repulsive salve. (This account is quite credible because in her native country it is widely believed that nursing a child as long as possible is healthy for both mother and child, and is also the best contraceptive.) The small girl discovered for herself the reason for this rejection: her mother soon showed signs of pregnancy. She therefore hated her sibling competitor even before birth.

At that time the patient fell sick. A pendulous tumor, which she mistook for a penis, developed in her groin. Her illness continued after her mother's delivery, about which many sadistic memories were recalled. Later on, the mother had to undergo an operation, and when she returned from the hospital, the "ungrateful" newborn failed to recognize her mother, one of the many reasons for the patient's hatred of this sister.

With puberty, the patient expected an end to her old doubts; she had longed for a penis, but accepted her female sex characteristics as proof of her femininity. However, she acted like a man, assuming responsibility for her family. Her father was a drunkard, a poor provider, unstable and disreputable, and in the girl's eyes represented everything opposed to

her concept of manhood. Her expectations of becoming a man were brought to the fore each month when her menstruation ceased. In her dreams she never relinquished this expectation. In one dream her sister gave her a penis which the patient introduced into her vagina, where it dissolved; in another she "eliminated this organ" while sitting on the chamber facing her father. Her expectation was expressed in her constipation, inasmuch as she identified the withheld feces with the "dissolved" or concealed penis. As soon as menstruation made her femininity obvious, her desire for a penis was silenced and the accumulated ingesta were eliminated.

Premenstrual Tension. By premenstrual tension or depression is meant a state of uneasiness preceding the menstrual flow and ended abruptly by it. The features of this depressive state are usually a striking loss of interest in the outer world, or an apprehension of some violent menace, transformed into either hyperactivity or lethargy. These psychic phenomena are usually accompanied by one somatic symptom or another, the most commonly observed being engorgement of the breasts and hypersensibility of the nipples. Less frequently the skin is afflicted and shows acne or herpetiform eruptions on face or back. Any other bodily region or organ may be included. These manifestations clear up with the onset of the menstrual flow. It must be mentioned that the oral or sexual sphere may be affected.

In my experience, this symptom is never manifested with the first menstruation and many patients claim that a specific happening initiated it, usually an abortion, a certain sexual intercourse (when connected with strong emotions), or, rarely childbirth. A few patients claimed that loss of their sex partner initiated it. In these cases menstruation is usually painful.

We are not astonished to find the most bewildering reports of their puberty among the patients afflicted with this symptom. A strikingly high percentage has a history of enuresis which disappeared some time prior to puberty, or more frequently, menstruation was mistaken for a relapse into this

old evil. This symbolism is understandable if we remember that dreams substitute one secretory function for another. A patient of my observation dreamed of spitting at a man with whom she was having an argument, then squeezing milk out of her breast into his eye. The excretory activities of this dream were understood by the patient herself to symbolize menstruation; they further demonstrate the abreaction of aggressiveness by spitting and squeezing milk, which are identical to menstruation. To clarify the symbolic meaning of her menstruation, it may suffice to quote this patient's concept of it: the flow frees her from accumulated poison. This concept is analogous to the psychodynamics which maintained her enuresis, by which she gave vent to her destructive wishes against her mother, who she believed to have castrated her.

Space does not permit us to discuss other menstrual or genital functional anomalies. Too scanty or too abundant a flow might parallel dominant character traits projected on the catamenia or the genitals. The psychological factor is paramount in those patients whose disturbance has been diagnosed as functional. The psychologist can gather important material even from patients whose menstrual disturbance is the result of obvious pathological lesions.

TECHNIQUE OF OBTAINING PUBERTAL HISTORY

The patient's response to the psychologist is, at first, strongly influenced by those who have interviewed, examined, or contacted her. The patient or suspect who has been referred to the psychologist surmises that her depositions, even the most personal and confidential statements, will be used against her, either to ascertain that her sickness is merely neurotic (to her the equivalent of insanity), or to prove her utter villainess.

This distrust must be eliminated as soon as possible, even if the patient disguises her neurotic resistance in this form. In order to establish the rapport, indispensable for a psychological examination, we must convince the patient that our endeavor is only connected with the first investigator's tasks, in-

asmuch as we are eager to obtain a specific background of sickness, the criminal deed, and so on.

It is obvious that questions disrupt the flow of thoughts of the interviewee. She wants to begin her account by presenting us with the actuality which caused her to see the psychologist. We have to listen to her presentation until the first excitement subsides. Then, some remark as to whether or not her past may have presented her with a similar situation will direct her attention to older experiences. Some positive response is likely to be obtained, together with some emotional outburst. If our interview succeeds in reaching this point, the patient's cooperation is almost secured and she will recall other crises in her past. The next pause in her narration may be filled with some seemingly purposeless, casual questions about background, siblings, and friends. According to the interviewer's resonance, the response is more or less detailed, but we try to keep the interviewee unaware of the purpose of our probing. Meanwhile, the puberty has been touched upon spontaneously several times by the interviewee, and we repeat one of these points in an interrogative form.

In the foregoing reports, many examples have been given showing the results verbatim. All of these patients were unable to understand the significance of their communication. Many of them volunteered important facts of their past, such as the death of one parent,—or after a long and significant pause—a sexual experience from childhood or any other emotionally important event. If no facts were reported, the patient brought up some associations the symbolism of which could be understood either immediately or later, if other parts of the history were obtained.

In monosymptomatic neuroses or uncomplicated psychosomatic symptoms, therapy can now be attempted because the material obtained seems sufficient for this task. Very often the patient suddenly realized the similarity or identity of her pubertal manifestations with those being investigated. There may even be a strong emotional reaction when anxiety and guilt feelings are touched upon. Establishment of transference

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helps at first to overcome the adversities mentioned previously, because the patient feels a great relief which she attributes to the psychologic interview.

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APPLICATIONS OF THE "MECHANISM OF ORALITY" IN NEUROSIS AND CRIMINOSIS

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There are two great riddles in criminology which are discussed time and again but remain unsolved: why are crimes committed at all, and why does punishment of crime not prevent future ones?

The history of modern criminal psychopathology—a very young branch of science—is one of descriptions—and fallacies. The descriptions are of observable facts, and are limited according to the ability of specific investigators to see at least the surface reverberations of an inner conflict. The fallacies are the result of attempts to apply methods and fact-material of other sciences to criminology: biology, sociology, psychiatry. The youngest and perhaps most dangerous fallacy consists of schematic identification by analogy of neurosis and "criminosis" (to use an excellent term coined by Foxe and already a part of the psychiatric nomenclature). Since Freud's psychoanalysis proved that in neurosis unconscious mechanisms are used, and since psychoanalysis elucidated the dark continent of neuroses, many authors in the field of criminal psychopathology apply, in a more or less modified or attenuated form, these discoveries to actual criminals. The procedure is fallacious, since the *psychologic contents* of a criminal action do not explain the actual *motor act* involved. Against this identification of neurosis and criminosis, serious objections have been raised, the most precise being that of Ben Karpman:

" . . . the psychoanalytic approach has as yet failed to contribute significantly to the solution of the problem because it gratuitously went on the assumption that the same mechanisms operated in criminals as in neurotics . . . The great majority of the professional and habitual criminals must be

approached by a method different from that used for neurotics."¹

The objection is fully justified, and, today, theoretically, more or less acknowledged. This does not prevent, of course, the constant repetition of the same fallacy by enthusiastic scholars who are happy to "discover", for instance, an Oedipus complex in criminals, and naively believe that they have explained the phenomenon of crime. They are disturbed neither by the fact that every human being goes through the oedipal phase nor by the fact that the criminal, instead of being content with a good-sized neurosis, perpetrates a deed which lands him in a prison cell or death chamber. A tragic example of this fallacy, which in general takes a more ludicrous form, is the *cause celebre* of Halsmann in pre-Hitler Austria. The reactionary medical faculty of the University of Innsbruck was asked by the court to express its opinion of the reason that a young Latvian Jew killed his father, a crime which the defendant denied and which could only be "proven" by more than doubtful circumstantial evidence. The Nazi-infested faculty decided that Halsmann had an Oedipus complex which was "operative". Freud objected to this biased nonsense, pointing out the universality of the Oedipus complex. Said he: "Even if the conflict between father and son could be proven, one must say that there is a great distance between this conflict and the causative factors of such a crime." Freud illustrated his point by a joke: A man was sentenced for robbery on the ground of circumstantial evidence, having been arrested near the robbed apartment with a skeleton key in his pocket. Asked if he had anything to add when his sentence was passed, he replied that he wanted to be sentenced also for adultery, having that "key", too, in his pocket². The "great" distance mentioned by Freud is exactly the distance between our present ignorance and the finding of the "specific factor" in crime.

Obviously the eradication of a misconception is quite a

¹ "The Individual Criminal", *Nerv. ment. Dis. Monogr. Ser.* # 59, 1935, Foreword, p. vii.

² Freud, *S. Ges. Schr.*, XII, p. 412.

job, since it involves overcoming the human reluctance to think, or the preference to think along lines of prefabricated patterns.

"But isn't the Oedipus complex the "basis" of Freudian psychoanalysis?" a reader, not familiar with our literature, might object. This famous complex, describing the *unconscious* libidinous attachment of the child to the parent of the opposite sex, with resultant *unconscious* aggressive rejection of the parent of the same sex, is admittedly one of the first and great discoveries of Freud. Its validity is acknowledged today far beyond analytic circles. But time marches on and experience increases. Freud himself described, 15 years before his death, the pre-oedipal substructure of the Oedipus complex, that is, the "oral" phase. In the first months of the child's life, only his relation to his mother exists; or more precisely, the child has difficulty in acknowledging the fact the he is not autarchic. The mother's breast (or the milk bottle) is given to His Majesty, the Baby, when he wants it. In other words, the fact that the breast or its equivalent are not automatically given (sometimes there are delays) is one of the great blows to the child's megalomania. This trauma is increased with the inescapable tragedy of weaning. During all of the first months, the child conceives his mother to be, not kind and charitable, but malicious and cruel, biting and draining others, one who can poison and devour. The witch in fairy tales (for instance, Grimm's *Hansel and Gretel*) is representative of this misconception and is based on the projection of the child's own aggressive impulses (biting the breast, for example) upon his mother, as our English colleagues have proved.

This pre-oedipal mother-relationship in the early months of each person's life is shattered because of its aggressive contradictions. The hatred for the mother—the same mother upon whom the child nevertheless depends for food and care—becomes unbearable. The boy then shifts his hatred onto his father, his positive feelings remaining with his mother, whom he now conceives of as passive-feminine and loving. The

father becomes the recipient of his hatred as a solution of the boy's unbearable conflict of ambivalence concerning his mother and because the boy now takes cognizance of the father's existence as a competitor for the mother. Thus the transition between the pre-oedipal and the oedipal phases is established.³

Yes, the Oedipus complex still has the validity it had 50 years ago, when Freud discovered it. It remains the root of hysteria (phallic level) and obsessional neurosis (anal level). On the earliest psychic level—the "oral" level—its precursor, the pre-oedipal conflict, dominates. *And in criminosis exactly this earliest, pre-oedipal conflict, is, in my opinion, decisive.*

To make our problem more difficult, there are on record, with few exceptions, no actual clinical analytical experiences with criminals in prison. With exception of a few attempts no organized analysis in prisons has been conducted⁴. The result is that, in general, clinical experience is lacking and theoretic misconceptions and ignorance are rampant. Such ignorance seems strange since there is no lack of inmates in prisons, nor lack of experienced psychanalytically-trained psychiatrists who would work a few hours a day at prevailing rates in order to conduct such exploratory analyses. The only things which are missing are money and an organization to set the undertaking in motion. Some time ago I proposed that a donation should be made to enable 50 psychoanalytically-trained psychiatrists to analyze for two years 500 criminals of all types in prison. A cross section of the material obtained in such an experiment might reasonably give the hope of some compromise in conclusion. The experiment would

³ The intermediary phases (anal, urethral) are omitted from this sketchy description.

⁴ Among these few exceptions are the analysis undertaken by Foxe, described in "Psychoanalysis of a Sodomist". *Amer. J. Orthopsychiat.*, 1941, and his analytic experiences with 35 criminals, described in his monograph, *Crime and Sexual Development*, Glen Falls Monogr 1936; Alexander and Healy's half-year experiment with a few cases of stealing, *Roots of Crime*, Knopf, New York City, 1935; Schilder and Keiser drew conclusions from unanalyzed murderers sent for observation to Bellevue, "A Study in Criminal Aggressiveness", *Genet. Psychol. Monogr.*, XVIII, Nos. 5 and 6; and lately, Lindner's hypnoanalysis of a criminal psychopath, *Rebel Without A Cause*, Grune and Stratton, New York City, 1944. Lindner mentions 5 similar cases.

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have to be conducted by a large group of physicians; one conducted by a few physicians, analyzing the same number of criminals over a longer period of time, would not be conclusive, since every physician involuntarily brings his preconceived ideas and personal scotoma into play. A cross section of the findings of *many physicians* would be an indispensable prerequisite. Strangely enough, no millionaire or group of millionaires has yet thought of such a means of income tax deduction; money is as yet not available for criminologic research work of this type.

The case material collected so far in the clinical psychoanalyses of criminals is so insignificant in amount, so inconclusive in results, that it simply excludes any possibility of basic conclusions, even if one overlooks the contradictions in conclusions of different authors achieved through different approaches. Tragic, or perhaps tragi-comic as it may sound, experience up to now allows but one conclusion: your guess is as good as mine—until experience proves otherwise.

Obviously, two approaches can be used in our present state of ignorance concerning criminologic problems: we can wait for the happy moment when the minimum of 500 cases in prisons are analyzed by some 50 or more competent psychoanalysts, whiling the waiting period away with castles in the air in the form of hypotheses, or we can try to clarify the issues in theory on the basis of "tangential" material which comes to our attention in private practice. I personally have chosen the second approach.

My analytic experience with criminals comprises approximately 20 cases, and includes 2 men who murderously assaulted wife and sweetheart respectively, 1 woman who killed her child, and 17 psychopathic personalities (5 kleptomaniacs, 6 impostors, 4 bankruptcy specialists, 1 extortionist, 1 woman who chronically accused men of rape). I am excluding from this collection all cases of perversion, despite the fact that some perversions, for instance homosexuality, are often combined with psychopathic trends; these would increase the material to at least 36 cases. In different papers I have given an ac-

count of these patients⁵. The directly criminologic material was "tangential"; in other words, the patients did not seek psychoanalytic treatment because of their criminal deeds—indeed, they tried to conceal these and brought them to light involuntarily.

In my opinion, the main confusion in criminal psychopathology is the failure to differentiate between two factors in every criminal action: a *variable* one and a *constant* one. The variable factor is made up of the *psychologic contents*, and is multitudinous in form, differing in every case. The variety of motives for a crime is as great as the variety of unconscious motives in general. The constant factor in crime is the unknown "X" which explains the *motor act* executing the criminal move itself. This constant and pathognomic factor I have proposed to call the "mechanism of criminosis". In my opinion these two factors must be determined in every criminal action.

The differential diagnosis between these two factors is accomplished by keeping in mind the following: the variable factor explains the unconscious contents of a criminal action. To explain these, we must use all of the knowledge of unconscious mechanisms which Freud has discovered and so successfully applied to the explanation of human conduct in general—unconscious wishes, defense mechanisms, projections, identifications, atonement of unconscious guilt feelings, etc. The constant factor, the mechanism of criminosis, refers, not to the variable psychologic contents of a specific crime, but to the motor act executing the results of the variable factor. I repeat, the real riddle in crime is the motor act. It borrows from the inexhaustible source of aggression, using it as the most primitive of human trends without revealing whether

⁵ "Suppositions about the Mechanism of Criminosis", *J. crim. Psychopath.*, V. 2, 1943. This paper contains also in Chap. I "The dilemma between our Static and Transitory Ignorance", a critical review of some of the theories concerning the reasons for criminal actions. "Psychopathology of Imposters," *Ibid*, V. 4, 1944. "Eight Prerequisites for Psychoanalytic Treatment of Homosexuality", *Psychoanal. Rev.*, 31, 3, 1944. "The Respective Importance of Reality and Phantasy in the Genesis of Female Homosexuality", *J. crim. Psychopath.*, V. 1, 1943. "Hypocrisy—Its Implications in Neurosis and Criminal Psychopathology", *Ibid*, IV, 4, 1943. "The Psychology of Gambling", *Imago*, 1936.

that aggression is primary or secondary (pseudo-aggression, that is, aggression used as an unconscious defense mechanism).

In looking for the mysterious "mechanism of criminosis", what has struck me particularly is that a mechanism which I discovered closely approaching it is visible in a specific group of neurotics—the "orally" regressed patients. These patients spend their neurotic career producing unconsciously the following triad:

1. Unconsciously they constantly construct situations in which they are refused and disappointed.

2. Then, after repressing their own initial provocation, they throw themselves, full of aggression and seemingly in self-defense, against their self-created or imaginary enemies, and fight them with righteous indignation.

3. As a final act, they revel consciously in self-pity ("this can happen only to me"), and enjoy unconsciously psychic masochistic pleasure.

In this triad—which I have called the "mechanism of orality"—the initial provocation and masochistic pleasure are completely repressed; the righteous indignation and self-com-miseration only are conscious. In my opinion, the triad is pathognomonic for all oral neuroses. In contradiction to prevailing views, I maintain that the contents of the oral phase are, not the wish *to get*, but the wish *to be refused*. The conflict is begun with the pre-oedipal mother ("phallic mother"), pertains to oral refusal, and is later projected onto innocent people. A few examples of this self-damaging technique:

A patient, coming for treatment because of ejaculatio praecox, told me the story of his life. Filled with rage and hatred, he said that he had continually met with bad luck in all his plans for marriage. The last attempt had failed because of the "malice" of his presumptive father- and mother-in-law, and a "lack of love" in the girl. He, a man 32 years of age, had fallen in love with a girl of 18. When the girl's parents made inquiries concerning his financial status, he represented his income as 80 percent lower than it really was. Alarmed at the prospect of such a "mismatch" the parents, who were calculating business people,

rich and rather purse-proud, and who wanted their daughter to marry only money, opposed the engagement and influenced their daughter to give up her fiancé. When the patient's relatives heard about this "awkward behavior" of his, in reference to his income, they were horrified. They had impressed upon him that in this connection it would be better to say too much rather than too little. When I asked the patient why he had not simply told the truth about his circumstances he answered that he had wanted to "test" his parents-in-law. Unconsciously, he had wanted to drive the girl and her parents into the role of "giving" persons *ad absurdum*, as if to say, "Nobody loves me; therefore I may be aggressive and enjoy my unhappiness." I was able to show that the failure of previous marriage plans had been brought about in a similar manner.

Another patient complained continually about his wife. Above all, he reproached her for "malicious refusal in sexuality". When I asked him of what this malicious refusal consisted, he said that his wife was "completely passive" in sex. The patient had married a virgin with a repugnance to everything sexual, who theroretically assented to coitus only because, as she said, one had to be "normal". Besides, she wanted to play the woman's part, passive and forced by the man. The patient, on the other hand, expected his wife to take the initiative in coitus and "seduce" him. When I tried to explain to him that the wish to be forced was typical in virgins, I met with complete absence of understanding. "What do you mean? I am to take the initiative? Ridiculous!" was his repeated reply. When I protested that if he wanted to be seduced he should have chosen an older and more experienced woman for his partner, he replied in an injured tone, "Oh, if the woman enjoyed it, the whole affair would give me no pleasure." Analysis showed that the patient did not really want intercourse. He wanted only to drive the woman, the dispenser, *ad absurdum*. In this he succeeded by means of a simple unconscious trick. Since both partners wanted to be seduced, a complete inactivity lasting for years resulted. The patient's wife was still almost untouched when he came to me after 7 years of marriage. Unconsciously the patient identified the sexually inexperienced woman with the "maliciously refusing mother" who denied him pleasure, toward whom, therefore, he could behave aggressively without feelings of guilt. He refused to have intercourse, did not even talk to his wife

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about sexual matters for years, and pitied himself masochistically because of the "bad luck" which he had unconsciously brought upon himself.

I was provided with another example while writing my contribution to this textbook. A man living in a town 1500 miles from New York called me long distance in the last days of August, asking if I had an appointment hour free. "When will you be in town?" I inquired. "In a few weeks or months," was the reply. "I cannot predict whether I shall have an appointment hour free at that time. Call up or write for information then, before you come." Two and a half months later the man called up again, informing me that he had just come to New York and wanted to start treatment. He consulted me and told me that he had read a paper of mine on homosexuality. Being a homosexual himself and wanting to change, he had decided to come to me, especially since I had expressed the opinion in that paper that, despite the prevailing pessimism concerning the curability of this perversion, I was optimistic provided a specific technique and selection of suitable cases were used. He had therefore decided to change his place of residence and enter treatment exclusively with me. As it happened, I did not have an appointment hour free at the moment, but told him that in a few weeks he could begin treatment. The man was deeply disappointed, since he believed erroneously that I was the only person who could help him. Confronted with the choice of waiting a few weeks or being recommended to a colleague, he chose the latter. Obviously, without knowing it, he preferred to be "refused" and "unjustly treated" in repetition of the "mechanism of orality" typically present in homosexuals. He preferred his grudge against the projected "bad mother" to starting cure with a physician whom he trusted, and will probably spend his time in analysis with the colleague complaining about the "injustice" I did him. That he provoked the whole situation by not writing and impatience is undoubtedly unknown to him.

As a literary example of this attitude of oral neurotics I shall cite an episode from the life of the poet Grabbe. Grabbe had been a military judge, and unresistingly allowed himself to be dismissed without a pension—through neglect of duty in a most provoking manner—and then expected his rich wife to support him. Though Grabbe was aware of the pathological miserliness of his wife, he let himself come to this state of dependence on her. She refused him all sup-

port; this caused Grabbe to flee Frankfurt and Dusseldorf. Later on, after he had been taken seriously ill, the police forced her to take him into her house. The unconscious meaning of his course of action was to drive the woman into the role of the denier in order that he might be aggressive without a feeling of guilt and thus enjoy self-pity (masochistic pleasure).

The "mechanism of orality" has, in my opinion, proven to be the key to the solution of all neuroses on the oral genetic level of libidinous-aggressive development⁶.

It soon became clear to me that, despite the similarity between the mechanism of orality and that of criminosis, there are specific differences which explain why they cannot be considered identical and why the mechanism of orality, pertaining to neurotics and perverts, cannot be directly applied to criminal cases. The mechanism of orality exhausts itself in the constant unconscious construction of situations in which someone is unjust, giving the person who provoked the injustice the alibi of defence-aggression and producing the unconscious pleasure of self-pity. The "mechanism of criminosis" differs in the following points:

1. Despite the fact that the starting point — feeling of being unjustly treated by the pre-oedipal mother — is identical in both the oral and the criminosis mechanism, it leads to dif-

⁶ The following neurotic diseases and perversions have become either therapeutically more accessible or curable for the first time through knowledge of this mechanism in its different specific modifications: pseudomental debility ("The Problem of Pseudo-Mental Debility", *Int. Z. Psychoanal.*, 1932); writer's cramp (Case II in "The Breast Complex in the Male", in collaboration with L. Eidelberg, *Int. Z. Psychoanal.*, 1933); ejaculatio praecox of the "hopeless" variety (On Ejaculatio Praecox, *Psychiat. neurol., Bl., Amst.*, 1937, and the corresponding chapter of "Psychic Impotence in Men", *Monograph, Medical Edition*, Huber, Berne, 1937); psychogenic aspermia ("Further Observations On the Clinical Picture of Psychogenic Oral Aspermia", *Int. J. Psycho-Anal.*, London, 1937); erythrophobia ("A New Approach to the Therapy of Erythrophobia", *Psychoanal. Quart.*, 1944); inability to write in inhibited writers ("On a Clinical Approach to the Psychoanalysis of Writers", *Psychoanal. Rev.*, 1944); perversion homosexuality ("Eight Prerequisites for Psychoanalytic Treatment of Homosexuality", *Psychoanal. Rev.*, 1944, and "The Respective Importance of Reality and Phantasy in the Genesis of Female Homosexuality", *J. crim. Psychopath.*, 1943, and "The Breast Complex in the Male", *l. c.*); retirement-neurosis ("A Test for the Differential Diagnosis between Retirement Neurosis and Accident Neurosis", in collaboration with O. Knopf, *J. nerv. ment. Dis.*, 1944); oral frigidity ("The Problem of Frigidity", *Psychiat. Quart.*, 1944).

ferent reactions. The *oral neurotic sufferer* creates the triad comprising the mechanism of orality. His feeling of helplessness is overcome by two devices. First, he repeats *actively* what he experienced originally *passively*, using the "unconscious repetition compulsion" (Freud), which restores the mortified narcissism. Second, he seems to overcome his feeling of helplessness toward the pre-oedipal mother by feeling consciously that he is aggressive in self-defense, despite the fact that he enjoys unconsciously psychic masochistic pleasure. The *criminotic sufferer* acts similarly to begin with, but his feeling of helplessness is apparently not overcome. The motor action in criminosis is based on the inner feeling of *being incapable of making the mother even feel that he seeks revenge on her*. The situation is that of a dwarf trying to annoy a giant who refuses to see these attempts. *There is a direct relation between the herostratic tendency in criminosis and the feeling of helplessness in making evident this revenge*. Because of his feeling of being a dwarf, the criminal uses, so to speak, dynamite. Of that the giant must take cognizance. The feeling of helplessness has nothing to do with "feeling of inferiority", feeling of being unmanly and feminine, with aggression in defense against it. It is a sensation which the child has *before* these other terms have any meaning for him. It is this deep feeling of dwarfism which the child in the criminal cannot "take". Secondarily, masculine and feminine identification and defense against passivity take place, as Schilder and Keiser have shown: however, they represent a *later* reflection of an early development.

Every criminal action has something herostratic about it. Herostratos was the individual who, in 356 B. C., burned the famous temple of Artemis in Ephesos in order to become "renowned". Our herostratic criminals perform similar deeds with another purpose: to force the mother of their first childhood to acknowledge that they are at least *capable of taking revenge upon her*. The deepest core of the criminal's conflict is the pre-oedipal helplessness and the feeling that the mother and her successive representatives do not believe that the child

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can help himself, even in revenge. This is the basis of the criminal's not being able to "take it".

2. The disproportion between the official reason for a criminal action and the exaggerated crime itself is explainable when we take into account that the underlying unconscious motive is the herostratic compensation for that deep feeling of helplessness to take revenge masochistically.

3. The unconscious acceptance of punishment is an inner prerequisite of every criminal action. One must not be fooled by the fact that this need of punishment does not appear on the surface. There are reasons to believe that the amount of self-damaging tendencies in criminosity is far greater than in every known neurosis.

4. The role of inner exhibitionism in criminal actions seems to have a disproportionate importance. The criminal's sense of self-preservation directs him to hide his crime, since *consciously* he does not want to be punished. His unconscious exhibitionistic masochism, on the other hand, wants to show up his deed, to prove to the mother that he was able to take revenge. The typical self-betraying "mistakes" of criminals are determined, not only by their unconscious need for punishment, but also by their unconscious need to exhibit the negation of their helplessness.

A more detailed differential diagnosis of the mechanism of orality and criminosity is found in the following tabulation:

"Mechanism of orality" in neurosis

1. Starting point: the feeling that the mother of the pre-oedipal period (or her representatives) is unjust and denying.

2. The feeling of deep injustice leads to the triad:

(a) Construction or misuse of situation to force someone identified with the phallic mother into the role of being unjust and denying.

"Mechanism of criminosity"

Starting point: Identical.

The feeling of deep injustice leads to the triad of the "mechanism of orality", with the following modification: The real or fancied frustration in early childhood results in absolute helplessness with regard to forc-

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(b) Repression of the provocation, with conscious feeling only of righteous indignation and resultant counter-aggression, seemingly in self-defense.

(c) Punishment from the outer world, unconsciously enjoyed masochistically, for that counter-aggression. The triad helps the neurotic to overcome his deep feeling of passivity by the facade of pseudo-aggressiveness.

3. Symptomatic and characterologic difficulties exhaust the need for punishment.

4. Exhibitionism plays a relatively unimportant role.

5. Superego is appeased by unhappiness resulting from self-constructed defeats which do not endanger the life.

6. Quantitative amount of inner passivity: insufficient to disrupt the Ego.

7. Childlike megalomania is satisfied in concoction of masochistic situation.

ing the mother to acknowledge the child's ability to take revenge. This inner helplessness is counteracted by a *herostratic act* (crime in its different phases) to force the mother (or her successive representatives) to acknowledge the child's ability to take revenge.

Social ostracism, prison, or capital punishment, unconsciously desired.

Exhibitionism is indispensable; it is used to demonstrate to the phallic mother representative that the child is powerful enough to force her to *see* that he is not helpless. (See next point).

Superego is appeased by expectation of punishment; therefore allows the "proof" of the mother's evilness. Self-betraying "mistakes" are necessary to appease unconscious need for punishment and also unconscious need to exhibit denial of helplessness to take revenge.

Inner passivity present in greater amount; defence against it stronger; in form of herostratic act and expectation of punishment.

Childlike megalomania prevents the criminal action from being a "perfect crime", since the assumption "Nothing can happen to me", based on the unconscious wish to be punished, and lack of complete thinking

through of all possibilities, based on the same self-damaging factor, work against that goal.

To sum up: The criminal commits his specific crime for two reasons: he is confronted with an unconscious conflict (variable factor) and solves this conflict by committing a herostratic motor act (constant factor), motivated fundamentally by an infantile, preoedipal pattern, also unconscious. It is, therefore, not true that everyone is a potential criminal. Criminality presupposes *specific* childhood conflicts and their insolubility. By the same token, it is not true that social factors alone or even predominantly explain criminality. No reasonable person denies sociologic facts; acknowledgement of them does not imply, however, that their importance should be exaggerated in every case. In many instances the social factor in criminal actions is either an excuse, or, more often, a rationalization for hidden unconscious motives, that is, the hitching point for the repetition of injustices experienced in reality of phantasy in the child-mother (later, father) relationship, afterward projected and perpetuated masochistically upon society.

The next question is whether the aggression shown in the motor act is original or whether it is a defense mechanism. In my opinion there is no doubt that it is a defense mechanism. I am in agreement on this point with Schilder and Keiser, and Alexander and Healy. Those four authors come to the same conclusion, though by different methods of reasoning. Their form of deduction seems faulty to me, but their results—which matter the most—correct. Alexander and Healy lay great stress on an "inner prestige motive". For instance, they regard stealing as "an attempt to regain the lost self-esteem by a kind of pseudo-masculinity", as well as an attempt to repair oral damage, which they regard, however, as a desire to "get" combined with the aggressive wish of taking away⁷. Schilder and Keiser state: "We conclude that in many instances aggressive action (in criminals) is a reactive state resulting from a sense

⁷ There are basic differences in evaluating orality, *vide*, above.

of passivity. The passivity is frequently felt as identical with homosexual trends." Schilder-Keiser do not take into account that homosexuality has an oral basis⁸, and Alexander-Healy interpret orality in a way not acceptable to me. Still, all four authors agree that the aggression in criminality is reactive—an interpretation which is a step in the right direction.

We are now in a position to answer tentatively the question as to why punishment does not prevent crime. To do so we must consider the structure of the unconscious part of our conscience.

The idea that the criminal has not developed an inner conscience (Superego) seems absurd to me. If his conscience does not prevent criminal deeds—as does a normal person's—the question arises as to what specific means he uses to appease his conscience. The problem is complicated, since the whole development of the Superego is still controversial, even in psychoanalytic literature. The very few facts known and more or less accepted are these: The core of the Superego consists of the introjected educational authority (mother-father and their successive representatives), as shown by Freud. What is introjected, however, is by no means the real mother and father, but the mother and father as the child sees them, through the spectacles of his own projections, as has been stressed by English analysts. When, therefore, the child projects a great deal of his own aggression upon his parents, he later introjects them as cruel and malicious, even though in reality they are mild and benevolent. To complicate matters further, the whole structure of the inner conscience is not fully understandable unless one takes into account Freud's Eros-Thanatos theory⁹.

The Superego makes itself clinically visible in its effects: feeling of guilt, need for punishment, sense of depression. In criminal action this need for punishment is clearly visible. All of the little mistakes which criminals make and which lead to

⁸ See "The Breast Complex", *l. c.*

⁹ Such an attempt was made by Jekels and myself in "Transference and Love", *Imago*, 1934. The problem is too complicated to be discussed here; reader who is interested in this hypothesis is referred to the original.

their detection have also an affective basis in the need for punishment.

The next problem is to what degree the feeling of guilt is the simple consequence of a criminal deed. How complicated this problem is becomes visible by comparing the following statements:

Schilder and Keiser: "We have no definite reason to believe that the wish for punishment, although present, is one of the outstanding factors . . ." (*l.c.*, p. 368). "As with most criminals, he wants to be punished, but not too severely. It is the attitude of the child, who regains the love of his parent after punishment." (*l.c.*, p. 367).

Zilboorg: ". . . As soon as the impulse is discharged and the special Id drives are thus temporarily gratified and silenced, the Super Ego reestablishes itself and asserts its demands. Even the hard, defiant criminal then feels unconsciously repentant. His challenging, snarling, boisterous defiance of the law, or his sullen, apparently indifferent, emotionless attitude is in most cases but an automatic covering, boastful or humbled, of the sense of guilt. The writer has never failed to find it deeply buried in the unconscious of apparently confirmed criminals of whom he had the opportunity to make a psychological study within the walls of a prison. Many criminals, as a result of this inner penance, kill themselves soon after the crime . . ." (*Mind, Medicine and Man*, pp 253-254).

I personally disagree with all three authors with regard to the deposition of the feeling of guilt. I disagree with Schilder and Keiser since I believe that the *unconscious feeling of guilt has the place of pivotal importance in criminal deeds and is automatically included in the deeds*. If the criminal did not know unconsciously that he would be punished, if he did not project his expected punishment upon the juridical and penal authorities, making them the executive organ of his own Superego, his feeling of guilt would prevent his deed in the first place. Only *because* he projects this expectation of punishment does he appear often detached and sometimes without

penitance¹⁰. I disagree with Zilboorg because of his conception of crime. For him, the criminal action represents a volcanic eruption of repressed Id-wishes followed by feeling of guilt. In my opinion, crime is not the outburst of an Id-wish but a defense against it executed by highly complicated means. The feeling of guilt does not appear post facto but is embedded in the deed itself. *Only this unconscious expectation of punishment makes the criminal action possible.*

And the practical application of all of these theories, hypotheses and suppositions? As long as no experiment of the type proposed in the beginning of this paper is conducted—the analysis of at least 500 criminals of all types in prison by at least 50 psychoanalytically-trained psychiatrists—we are forced to remain in the realm of supposition in criminology. Some authors compensate for prevailing ignorance by over-optimism, some by over-pessimism, concerning the future possibilities of the therapy of criminosis. *The simple fact is that we just don't know.* I am against the attempt to drag criminal psychopathology into the prediction business. I personally feel mildly pessimistic about future successes in treating criminotics. My doubt is based on the difficulty of changing even those neurotic patients who have a great amount of self-damaging tendencies, and the most neurotic individual uses a different, but undoubtedly *less* self-damaging technique than the criminotic. The vast amount of psychic masochism in criminals makes me suspicious of their curability. I would like to mention two illustrations of their therapeutic inaccessibility, the one reported by Alexander and Healy, the other from my own experience. In *Roots of Crime*, the two authors mention the case of a young man who, after hearing of the possibility of being analyzed in prison (the experiment was publicized), gave himself up in order to undergo analysis, received a two-year prison term for previous offenses (there were warrants out for him), but discontinued analysis after a short while with threadbare excuses. My own experience was as follows:

¹⁰ However, should the Schilder-Keiser assumption prove correct, to my surprise, it would give us a possibility for a successful therapy of criminosis.

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In the Psychoanalytic Clinic in Vienna we had, many years ago, the possibility to observe a "mass experiment" on a small scale, supplied, strangely enough, by a regular court¹¹. There was at that time a judge who harbored the naïve idea that psychoanalysis could cure any perversion, even *without* the patient's cooperation. For a time, therefore, he did not sentence perverse exhibitionists who repeatedly offended to the rather long prison term usually imposed. Instead, he passed a suspended sentence and remitted their punishment if they could prove after 6 months that they were under psychoanalytic treatment. Five cases were sent to the Clinic, where they were to be treated free of charge. Of these five persons, who faced the alternatives of imprisonment or psychoanalysis, one began analysis with one of our colleagues and promptly gave it up a few days after receiving the written confirmation that he had begun treatment. Two others did not appear after the first interview with the head of the Clinic. With the two remaining I spoke once or twice. After being told that they could start treatment, they withdrew with the most threadbare excuses. All four allowed themselves to be imprisoned. How can this grotesque situation be explained? Even fear of the alleged unpleasantness of the treatment cannot be used as the reason for the behavior of these four individuals, since they had no idea of what the treatment consisted. They could not have had any antipathy for the particular physician who would treat them, since each spoke with three physicians on the staff at the Clinic. Nor was there a conspiracy, for there was no proof that they even knew each other. From the discussion I had with two of them, I received the impression that imprisonment from time to time was an inseparable part of their psychic equilibrium. It gave them the opportunity to atone for their inward feeling of guilt. The prison term gave them, so to speak, the ticket permitting their next perverse action. Also striking was the awkwardness of their behavior when they were caught. They actually provoked arrest. One of them, for instance, was threatened by an old woman who saw his exhibitionistic act with a child from the window of a third floor. The man ran away, but returned in a few minutes, his rationalization being that he wanted to see if the old woman was still there. She was exactly where he suspected

¹¹ Reported in my paper, "Eight Prerequisites for the Psychoanalytic Treatment of Homosexuality", *l. c.*

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she would be, but had with her a police officer, who arrested the man.

Not only was imprisonment preferred by these two sick individuals, but it had become part of the routine of their lives. One of them had a small business delivering packages by car. When the occasion arose for a prison term, he told his family that he had to make a business trip into the country. The "business trip" was undertaken in jail. Another worked in his brother-in-law's print shop, and he was able to convince him that he had to take a trip occasionally to the mountains in order to keep fit. In this instance, the vacation was spent in jail. One could not but feel that treatment would obviously have disturbed the vicious circle of unconsciously self-provoked punishment, with the license it gave unconsciously to continue the perversion.

These examples show why one must have some doubts in respect to a future therapy of criminals. Judicial punishment is in some cases not punishment at all but unconscious temporary solution of a guilt conflict¹². The punishment is not dreaded but unconsciously expected by these sick persons.

I do not wish to imply that I consider every criminotic altogether unchangeable. I myself have been quite successful—as have been others¹³—with a few exceptional cases of criminal psychopathic personality¹⁴. That some can change is also

¹² Interestingly enough, Freud suspected as long as 30 years ago that some criminal actions were performed because the criminal had an unconscious feeling of guilt stemming from other sources. He spoke of "Verbrecher aus Schuldgefühl". In these cases the feeling of guilt was not the result of the criminal deed but the criminal deed the result of feeling of guilt.

¹³ The problem of changing these patients by applying different methods and interpretations is an interesting one. Very often it is not necessary to penetrate to the deepest oral layers, and "success" can be achieved through touching only superficial, for instance, oedipal, structures. In my opinion, we are faced in such successes, not with genuine changes, but with "success because of unconscious fear". In other words, in some cases, when essential motives are analytically touched upon, directly or indirectly, such strong defense reactions are aroused that the patient unconsciously renounces the symptom, though without otherwise changing his psychic structure, rather than selecting the radical course of running away. I believe that these patients give up their symptom in order to preserve their deeper-lying unconscious tendencies of a pleasurable kind and to withdraw from analysis. Freud spoke once of the "flight into health". The unfavorable aspect of the "success from fear" is the virtual certainty of a relapse. Either the old symptoms and signs reappear or they are substituted by "replacement" symptoms. The therapist is taken in by the unconscious of the patient without knowing it, if he simply follows his lead to the superficial layers, avoiding the oral substructure.

¹⁴ Reported in "Psychopathology of Impostors", *l. c.*

indicated by the records of some first offenders, who became law-abiding after a prison term, and by those who are helped and restored by the parole system. Since we know so little about the inner workings of the criminal psyche, we cannot determine the reasons for their change. It is possible that the childish part of the personality, confronted with the reality of prison, exhausts its feelings of guilt in the actual punishment. On the other hand, these first and single-time offenders are perhaps "borderline" criminal cases from the beginning. In contrast to these cases is the legion of others—undoubtedly the majority—who, despite punishment, continue their criminal careers.

But we have dealt so far only with "small fry" among criminotics. As yet not even one real murderer has been analyzed in prison. Everything we can say about him is speculation and is better suppressed.

One fact is clear: no punishment prevents crime. Responsible for this fact is the unconscious calculation on punishment in the criminal's deed. It is an integral part of the crime. The dread of punishment can therefore not forestall crime. Paradoxically, to quote an ironically-inclined patient of mine, a criminal lawyer, dread of punishment is more necessary for non-criminals than for criminals. The non-criminal needs unconscious recompense for being a life-long good boy. Therefore, public opinion asks for severe punishment of criminals. The majority of habitual criminals are unchangeable. This is only a reminder to be less optimistic about the penal results—especially in the case of second or third offenders—and to have less illusions about persons having "learned their lesson". People in general and criminals in particular don't learn so easily.

Every society must protect itself against individuals who do not accept the rule of the community. Criminal deeds are outside of the social game; they represent specific solutions of a specific inner conflict, and endanger the community as a whole. The habitual criminal himself has nothing to hope for from the solution of the enigma of crime. He will very

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likely be treated *morally* differently; he will be acknowledged to be a sick person. *De facto*, he will pay for the omission of the moral odium with disadvantages, for instance, lifelong detention. The moment the illusion of betterment and rehabilitation of habitual criminals through punishment is abandoned because it does not work, society will regretfully impose lifelong detention on the habitual criminal, not because he is "bad", but because he is a danger to the community. Whether or not a future therapy will be capable of helping him is today a matter of conjecture.

Our great hope for the future is that criminal psychopathology will, after overcoming its childhood difficulties, become a real help, perhaps even a therapy. Perhaps the solution of the criminologic problem will lie in child-analysis, when we no longer wait until the damage is done but treat difficult children in a preventive way. At the present moment, criminal psychopathology is still in the stage of sporadic experimentation, constant hope, abundant theories—and very real lack of clinical experience.

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ROBERT M. LINDNER, Ph.D.

The intra-mural treatment of the prisoner who needs psychiatric help is fraught with many hazards not to be found in the private practice of this specialty. In the following discussion, we will eliminate from consideration the psychotic, who will be managed similarly to this same type in a mental hospital, and who will contribute an inconsequential number of cases to the work of the prison clinician. The major fields of effort encompass psychoneurotics of all degrees of severity, the sexually chaotic, and—the largest group of all—the psychopathic personalities.

The primary difficulty in intra-mural practice rests in the fact that there is little incentive to recovery. Since the prisoner's aberrative behavior is the best means of adaptation of which he is capable, a powerful agent is wanted to encourage reality acceptance in the face of the disappointing prospect that his sentence will *not* be terminated any sooner, nor his lot within the institution be markedly improved. The tremendous amount of neurotic secondary gain, inherent in the prison situation, makes therapy inconceivably more difficult.

Another serious impediment to treatment rests with the transference situation. Inmates are generally suspicious—and some with good reason—of the psychotherapist's intentions. There is an unfortunate but popular tradition regarding the "bug doctor". He is identified with the powers that be, on the one hand, while there is, on the other, a notion abroad that he is less capable, less qualified, and even less self-sufficient than his colleagues in the civilian pursuit of their profession. Moreover, the lot of the inmate who makes daily visits to the psychotherapist is not an enviable one. Not alone

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is he subject to the raillery and derision of other inmates, but he rarely finds sympathetic support from custodial officers who, it cannot be denied, are themselves either envious, fearful, or otherwise insecure in their relationship to the therapist, and somewhat anxiously suspicious of the inmate who is being subjected to the unknown ministrations of the clinician. Furthermore, an ever-present and not lightly to be dispelled fear among inmates is that of being declared insane and sent to a mental hospital, thus entailing the loss of many privileges and incurring the unjustified but real stigma of insanity. And, finally, not to be overlooked is the trepidation of the confined offender lest he be "tricked" or somehow "forced" to reveal past crimes for which he will be held accountable.

In order to overcome, in so far as possible, this atmosphere of suspicion, fear, and general difficulty of rapport, a technique of psychotherapy is needed that will not depend upon the voluntary surrender of "secrets" by the patient, but will operate to disintegrate resistences and minimize the hazards we have already outlined. Time, too, is an important consideration in choosing a therapeutic tool, since the available services in prison are chronically understaffed, and the economic aspects of the problem are equally important. It would seem that to spend eighteen months to three years on a patient in prison—the time required by psychoanalysis, for example—is not only economically wasteful but sheer folly where the need is so great and the salvagability from society's point of view is debatable.

The method of hypnoanalysis appears to meet successfully the various criteria for a good psychotherapeutic tool for use with prison inmates. It is a research and treatment instrument which appears to combine the virtues of dynamic depth psychology and hypnosis, drawing on one for its referential and theoretical framework, and on the other for its incisiveness in penetrating to pathogenic sources. From psychoanalysis it takes the technique of free-association and the dialectics of psychodynamics which Freud and his followers have evolved:

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from hypnosis it commandeers a method for probing the repressed and deflected, exploiting and reinforcing the transference relationship, and dispelling resistances. As a result, it is an abbreviated and heroic method which has already demonstrated its wide applicability and its essential helpfulness. It has been especially successful with psychopathic personalities, a problem heretofore unamenable to therapy and one which afforded the least hope of all encountered intra-murally. In addition, it has been used with uniformly good results with prepsychotics, anxiety neurotics, homosexuals, hysterical somnambulists, alcoholics, kleptomaniacs, conversion hysterics, and inmates showing simple adult maladjustment. In general, it would seem to be indicated where the psychogenic component in disorder is central, and where there is offered to therapy a relatively intact ego.

It is not possible within the limits of this paper to do more than merely sketch the method of hypnoanalysis. The interested reader is referred to the items in the bibliography for a more thorough appreciation of its rationale, scope, and technique, as well as for the prerequisites which a therapist should possess before attempting to utilize this special tool. However, a brief summary of the method will serve to introduce this highly absorbing technique, and to allow an estimate to be made of its particular adaptability for prison work.

A course of hypnoanalysis begins with the patient receiving a thorough training in hypnosis. In the experience of this writer, any inmate who is willing to go so far as outward conformity to the therapist's directions can be hypnotized. It has been found best to begin with an informal discussion aimed to dispel the fears about hypnosis which pervade the popular mind. Until this has been done, it is useless to begin treatment. This done, training in hypnosis is embarked upon. The initial period should last no more than one week of daily sessions. At the end of this time, if the therapist has proceeded properly, the patient should be able to go into trance at the suggestion of the clinician, he should be able to carry out post-hypnotic suggestions faithfully, and he should be able

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to revert memorially to scenes and events of biographical significance.

Following the period of training—during which time it has been found better for eventual therapeutic success to avoid discussion of or reference to the peculiar problem or perplexity which brought the patient to analysis—the period of active therapy is begun. The patient is instructed to associate freely in the manner traditional with orthodox psychoanalysis, and the procedure is essentially the same. The point of departure occurs, however, when resistances are encountered. Parenthetically, if at any time during these opening phases the patient shows signs of breaking away or discontinuing the treatment before the full development of the transference, it can be revitalized by appropriate post-hypnotic suggestion and the patient thereby encouraged to continue treatment. This is a feature of hypnoanalysis which has a real value in the penal situation. One receives satisfactory assurance that a patient will not—indeed, will not want to—break away before he is dismissed.

When resistances are encountered and not immediately surmounted, the patient is hypnotized, brought to a stage of trance wherein he can readily and fluently verbalize, and requested to continue his associations from the point at which the free-flowing of material ceased in the waking state. There then follows a flow of analytically significant material which explains or elucidates the problem and accounts for the appearance of resistances.

As the core of the analytical material is approached in this manner, a stronger technique is often necessary to make comprehensive the dramatic and decisive items toward which the analysis is aiming in free-association or under hypnosis. This will, as we know, consist of the constellation of traumatic events and settings in the history of the organism of psychogenetic consequence, and a return to that period under hypnosis is advisable. There are alternate roads to the realization of this hyperamnesia. In one, known as *regression*, the patient is encouraged to look back upon an event which he

then recounts from the point of view and attitude of his present orientation as an adolescent or adult: in the other, the *revivified*, the patient is actually returned to the scene of the historical incident and literally lives it out, reenacts it, with all the powerful dramatic and emotional qualities inherent in the original episode. Two methods to differentiate these memorial types are available to the hypnoanalyst. The regressive type of recall, he will find, is not so vivid as the other and there will rarely be demonstrated histrionic side-effects, while the patient will appear somewhat sophisticated in regard to the incidents remembered. In the *revivified*, however, since the patient is literally resident in the traumatic scene, he not only cloaks himself in the personality of the earlier time, but he also assumes all of its appropriate motor behavior. At the same time, the ability to verbalize is not drastically curtailed. Thus the manner in which simple acts are performed (a pencil held, a shoelace tied, a garment buttoned) serves as an index to the time at which the event transpired. If it is important to preserve a record of this feature of analysis, or further to substantiate the validity of the age-regression, the use of such standard aids as the Goodenough Draw-A-Man Scale or the Gesell norms are recommended. In general, the regressive return should be utilized in the early stages of treatment, and the *revivified* held in reserve for the crucial disclosures that will appear toward the climax of the analysis. On the other hand, in some cases this will be utilized immediately at the beginning of treatment to check on the authenticity of the preliminary history of the patient in order to form a basis for planning treatment. Moreover, it will also serve from time to time as a reliable method to validate information and obviate both screen-memories and fantasy.

It is of central importance that abreaction be participated in by the entire performing organism. To the point we have described, the most important material, from a biographical point of view, will have appeared for the most part under hypnosis, and despite the great show of emotion accompanying *revivification*, the total organism will not have been involved.

It is in connection with this fact, among others, that a still not completely understood but well authenticated phenomenon makes its appearance. This is the *interim phenomenon*, which provides that, whenever a post-hypnotic amnesia is imposed on the patient for these crucial revelations, they will appear spontaneously in the waking state when the organism is psychologically prepared to receive and assimilate such decisive information. The importance of this phenomenon cannot be overestimated. It obviates at once the tiresome and time-consuming job of analyzing and resolving resistances. More significantly, however, it readies the organism for the revelation of the repressed. Were it not for this mechanism the hypnoanalyst would have to avoid the working through of certain psychogenetic episodes until his clinical experience intuitively advised him that his patient was prepared for their reception, and since the margin for error in such a procedure is so small, there is the risk that the analysis might end catastrophically for all concerned. This writer has elsewhere described such an instance.

If a post-hypnotic amnesia is induced for every trance session, the analyst can handle each episode as it is revealed in waking association with the assurance that the organism has been prepared in the interim, and that abreaction can be afforded it without danger. If abreaction does not take place in the waking state, the therapy will not properly be hypnoanalytic and will deserve all the criticisms usually directed toward those treatment forms which are based upon the superficial suggestive techniques. Should this occur, the permanence of amelioration and improvement is open to question, and relapses are to be expected. At all times must the hypnoanalyst guard against the use of suggestion instead of analysis aided by hypnosis and abreaction. It is well-known how symptoms have the most amazing way of disappearing almost magically under suggestion, only to reappear in the same or another form, with consequent damage to the patient's rapport and confidence.

When the pathogenesis has been clarified and adequate abreaction accomplished, there remains the task of re-education and re-synthesis of the personality. This is particularly important in the penal locale because the patient has obviously been resorting to unsatisfactory if not abnormal mechanisms of adjustment, and what is called for is a complete reorientation not alone toward the self but toward the world. His behavior has been founded upon a series of misconceptions, misidentifications, unhealthy attitudes, and insufficiently effective or poorly implemented defensive mechanisms. To correct this after psychodynamic exploration, hypnoanalysis resorts to the transference situation, exploiting it to the utmost with the aid of post-hypnotic suggestion to engraft the new and more wholesome proposals which have emerged. If the therapist does not act decisively to fill in the psychological vacuum created by the eradication of the pathological processes and unhygienic mechanisms of defense, the inmate's criminalistic environment will. Actually, the only way to make this a permanent process is to incorporate them completely into the personality in the same manner as a graft is made an integral part of a living tree. Only when the patient is fully reconciled to, and familiar with, the changed values, attitudes, and ways of regarding the past, and when he has fully demonstrated his acceptance of them in all phases and on all levels of his personality, is he ready to be dismissed by the therapist. It is here that the skill of the hypnoanalyst receives its supreme test. The judicious dissolution of the transference and the displacement of its energies call for surgical finesse.

Numerous problems confront the clinician who essays to use the therapeutic tool we have been discussing. The danger of departing from hypnoanalysis has already been mentioned, but the therapist is again urged to keep foremost before him the caution that suggestion is a subtle foe, and that to exclude it from the treatment process requires eternal vigilance.

Perhaps even more fundamental to the successful practice of hypnoanalysis is the personality of the therapist himself. The setting for the therapy is replete with temptation and dan-

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ger. Because of the fact that the transference relationship is different from and more intense than that found even in psychoanalysis, the therapist must himself be well-balanced and mature. To be otherwise would mean that upon the prone, plastic, pliable patient would be worked out the personality deficits of the therapist rather than the clinically objective re-orientation which is the aim of the scientist. The patient must emerge from treatment as an individual with a well-integrated personality. He must not become a carbon copy of the hypnoanalyst. Perhaps in just this lies the critical vulnerability of the technique. So serious is this danger that the clinician who attempts such a type of therapy owes it to himself and his charges to evaluate and understand his own motivation thoroughly. He must ever be on guard against losing control over his own intimate wants and impulses. It is necessary also that the hypnoanalyst, in addition to his scientific training and personal qualifications for this variety of treatment, if he is to operate in penal work, have the attractive qualities of understanding, personal prestige, and leadership assets in the eyes of the inmate group apart from his formal status. There is, as we know, an inclusive if not completely verbalized identification of every official who works in a prison with "authority". This mold can be broken only through the sincere efforts of the hypnoanalyst himself.

Apart from its value for therapy, hypnoanalysis is a unique research tool. In the penal situation it can and should be employed in an investigative manner to ferret out the obscure and complex dynamics of crime as well as the psychogenesis of behavior disorders. While not specific for penal practice, it seems at this writing to be an eminently useful and rewarding way of approaching the functioning organism. On the basis of its performance and promise, it deserves the attention of psychotherapists.

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PENTOTHAL SODIUM: AN AID TO PENOLOGIC PSYCHOTHERAPY

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INTRODUCTION AND HISTORY

In view of the ever increasing number of severe psychiatric disabilities requiring depth therapy, research has been directed toward finding some technique which will make the unconscious readily and rapidly accessible. The promising reports of the use of narcoanalysis and narcosynthesis with military problems suggested that the same technique would be of value in studying delinquents.

Until recently, drugs were used largely to promote hyper-suggestibility in the psychoneurotic^{1,11,16} or to induce lucidity in the catatonic schizophrenic^{2,3,12,14}. Horsley is to be credited with the introduction of narcosis to facilitate analysis (1936, nembutal), a procedure he termed "narcoanalysis"^{10,11}. He defined narcoanalysis as " . . . an eclectic technique based on the observation that a combination of narcosis with psychotherapy is quicker and sometimes more effective than the formal methods of analytic psychology." After wide investigation^{5,6,18}, clinicians at present prefer pentothal sodium because it is "safe, rapid, and sure"⁴.

Most studies in narcoanalysis were done in connection with the war-stricken patient whose personality and situation are somewhat different from the penitentiary inmate. War neuroses are acute in onset, situational in character, and are superimposed upon physiologic and psychologic fatigue. The soldier's psychiatric struggle is with himself, making the appeal to patriotism and responsibility to his unit a reasonable therapy. Moreover, there is the reward of restoration to duty or honorable discharge from the Service. The run of the mill prisoner, on the other hand, since he is in conflict with society,

is extraordinarily resistive lest he betray himself to custodial authority. His problem is largely a personality defect and to cloak inner conflicts he tends to lie, rationalize, and project freely. Furthermore, the inmate is faced with the unalterable reality of incarceration and commonly finds an avenue of escape in secondary gains of illness or through compensatory, aggressive behavior. Frequently he displays little genuine willingness to sacrifice fantasy for reality and rejects psychiatric interpretation and therapy as well as the inspirational rehabilitative program of the prison system.

The major initial problem of the penal psychiatrist is, therefore, the development of rapport with the inmate. He must avoid identification with authority in the inmate's mind. He should strive to develop rapport with the inmate body as a whole and with the individual inmate on a personal basis. The development of rapport is described in another paper in this volume. Once rapport is established with the inmate, how incredibly infantile is his dependence and how revealing of his intense affect-hunger!

THE SETTING

Applicants for narcoanalysis were admitted to the Neuropsychiatric Ward for administrative reasons until treatment was completed or interrupted for reasons noted below. As evidence to the inmate body that there is no compulsion to take treatment, all requests for it must be in writing.

At Lewisburg, facilities consist of a separate floor with a private room for each patient. Weaving, reading, music, writing, occasional walks, and games are provided for occupational therapy. Group discussions are encouraged and utilized to clear up psychiatric misconceptions. Under direction, patients are urged to socialize and improved ones are assigned to assist the new arrival in orientating himself to Ward routine. This helps considerably to develop the inmate's confidence in the physician and diminishes his fear of "the shots".

The therapist's attitude in dealing with the individual patient must be dominated by optimism and objective sympathy

tempered with firmness. He must support him during the trials of treatment and make every effort to avoid identification with the victim of the inmate's offense. The subject's complaints must be regarded as valid and all moral judgment of his past behavior suspended. In brief, to the physician, the inmate should be considered a rich opportunity for the study of the psychodynamics of crime.

THE DRUG

After wide experience, pentothal sodium was chosen as being superior to other barbiturates. It is detoxified by the liver and excreted by the kidney with no damage to either organ, it produces no untoward effects upon the cardiovascular system, and central nervous system changes are promptly reversible¹⁵. That the drug is safe is attested by Heard's report of its use for anesthesia in 8500 cases with only three deaths, none of which was attributable to pentothal⁹. Moreover, he notes that less than ten per cent of this group exhibited idiosyncrasy in the form of twitchings and general muscle and laryngeal spasms, which manifestations cease upon interruption of the drug. It may also be noted that addiction has not been reported.

Certain precautions are indicated. Due to respiratory depression, care must be taken to insure patency of air passages. False teeth are to be removed and subjects afflicted with arteriosclerosis, congestive failure, bronchitis, asthma, and anemia are to be excluded. Since the drug is detoxified by the liver, subjects with diseases of this organ should be rejected. Moreover, pentothal is contraindicated for children under fourteen years as well as adults over sixty because of their peculiar respiratory sensitivity⁴. Artificial respiration with 95% oxygen and 1 to 3 cc. of coramine administered intravenously are recommended for respiratory failure. Phlebitis, which occurs rarely, responds to wet dressings and can be minimized by the use of a pentothal solution which is no greater than 5%.

Barbiturates, given intravenously, produce an euphoric clouding of the consciousness with diminished discretion and

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resistance. Subjects become relaxed, confidential, and manifest increased suggestibility while hypermnnesia and abreaction are facilitated. At times depression, hysterical laughter and crying, as well as excitement, appear¹². Studies dealing with nosologic groups reveal significantly that normal and psychoneurotic subjects experience no change in perception and that their affect is outgoing¹³. This promotes intimate contact and increased communication, while anxiety is appreciably reduced.

THE METHOD

Selection of Patients

Patients were selected with total disregard for intelligence level, developmental background, character reliability, insight and judgment, suspiciousness, or degree of plasticity.

Phases of Therapy

Transference: Deep positive transference is not as essential as with orthodox analysis and, once the subject is under the influence of pentothal, the presence of others offers no interference. The physician assumes the role of a sympathetic parent who provides utmost support and encouragement during abreaction. Negative transference, evidenced by seclusiveness, irritability, and misbehavior, is fairly common.

Explanation of treatment: The subject is taught that he is emotionally sick. Psychodynamics are explained to him with due consideration of his intellectual level and accessibility. The principles of treatment are outlined and the principle of determinism is emphasized. He is introduced to the unconscious and its painful content, as well as the reasons for resistance. The dynamic influence of unconscious material, because it is beyond the scrutiny and judgment of consciousness, is referred to constantly. The inmate is informed that all functional physical complaints will be callously disregarded and the method of psychotherapy, consisting of free association, dream analysis, and full abreaction, is explained to him with the understanding that pentothal sodium merely facilitates treatment. He is warned that once free-floating anxiety is released, he may suf-

fer depression, headache, and sleeplessness, but assurance follows that these symptoms are transitory. Finally, he is encouraged to expect a "cure".

Induction of narcosis: The following is a slightly modified version of the generally accepted practice. Under usual sterile precautions, 0.5 gram pentothal sodium is dissolved in 10 cc. of chemically pure water to make a 5% solution (0.1 gram to every 2 cc. of water). An ordinary 10 cc. syringe is used with a 24 gauge needle which helps to inhibit the rate of injection. On no occasion has more than 10 cc. (0.5 gram) been used for an analytic session; the average used in this series was 5 cc. (0.25 gram). The patient must not have eaten for at least 2 hours prior to treatment. He assumes a recumbent position on a bed in a room with subdued light and with his collar and belt loosened. The condition of his bowels and bladder is of no moment. The solution is injected into any prominent cubital vein at the rate of 2 cc. (0.1 gram) per minute and is accurately timed. The subject is reassured as the solution is injected and told to count backwards from 100 or to speak freely should ideas occur to him. The usual reaction to the drug consists of thick speech, skipping of numbers or forward progression in counting, and yawning. The subject expresses a feeling of dizziness and sleepiness, and then relaxes. His color is good throughout the entire treatment and, while his pulse is reduced, it remains of good quality. The depth and maintenance of narcosis is determined by that state which promotes the greatest degree of productivity and accessibility at each session. As a matter of clinical choice, narcosis is pushed to the point of sleep. Obviously, this routine varies with different patients as well as at different sessions. Resistant patients during this stage toss about, wrinkle their foreheads, grimace, lick their lips, complain of dry mouth, and evidence a respiratory irregularity which is not alarming if it is part of this syndrome. Naturally, respiratory depression, spasmodic cough, and tremors demand immediate interruption of the drug. In our experience these signs did not appear. *Severe abreaction necessitates deeper narcosis to promote am-*

nesia. All effects pass off quickly. If narcotic sleep lasts from one to two minutes, the subject is entirely normal within one half hour; and if it has lasted five to ten minutes, normalcy returns in from one to one and a half hours. In our experience with at least 200 injections no disagreeable after effects were observed in any patient except for the psychopath who occasionally displayed severe delayed abreaction or abdominal pain and nausea, and, in one instance, vomiting, all of which proved to be psychogenic and transitory.

Narcoanalysis: Treatment was given twice weekly, as a rule. Clinical impression suggests that the post-anesthetic period is optimum for analysis, with the patient maintained in a light narcosis, "the true hypnotic state"¹¹. Deep narcosis is used to induce amnesia when abreaction becomes so severe that negotiation of elicited material must be deferred. The last five to ten minutes of each session, when the patient is relatively lucid, are devoted to interpretation, suggestion, and the fixation of reviewed material into consciousness in order to remove the danger of renewed repression or the development of a dissociated system of thought.

Three types of initial response appeared. The commonest group was characterized by spontaneous, coherent speech which revealed significant material. This group felt euphoric, passively receptive, and abreacted excellently. Next in order of frequency was the reaction of guarded speech. These individuals required prompting from the beginning of the hypnotic state and frequently they asked for more pentothal, promising secrets in return. Lastly is the individual characterized by spontaneous, rambling, delirious speech which should be listened to carefully for a possible clue. After this initial reactive stage, when the subject is capable of hearing and responding as determined by simple tests, and his attention is fully arrested and maintained by the doctor, prompting may be necessary. The major objective of prompting is to stimulate free association. Exhortations to recall and elaborate commands, threats of dismissal from the Ward, and interpretive analytic shock are useful. Questions based on a known situa-

tion or person should be simple, clear, and deliberate. Feelings are suggested to arouse the psychic counterpart. Special care is indicated in prompting the psychopath, for he may smart under transference and, as noted in our case material, threaten the therapist. Another objective is to create doubt in the patient's mind regarding incidents in the past so that he may seek buried complexes rather than deny their existence. Finally, utterances may or may not be recalled by subjects during their lucid period and some of them are worried lest they have spoken of things which might be damaging to their welfare.

The technique of narcoanalysis used is briefly that recommended by Hart⁸: "Any method whereby the nature and relationship of the causes responsible for the patient's condition are determined and removed by rearrangement and readjustment of these causes"⁸. Slips of the tongue are carefully noted and dream analysis elaborated through free association. Suggestion is useful for conversion phenomena and, as with hypnosis, must be firm, sharp, and repetitious. It should follow a fixed pattern: first, recognition of what the patient feels; then, graduated changes of recovery; and finally, strong suggestion for full recovery carried into the waking state.

PERSONALITY SYNTHESIS

It is obviously not enough to recall repressed material. This must be followed by conscious assimilation. When the ego's scope has been enlarged and theoretically is capable of scrutinizing and understanding unconscious conflicts, it is open to suggestion and corrective reeducation without the use of pentothal. Known psychodynamic causes of the patient's condition are discussed and fixed into awareness. The ego is taught to abandon projection and to understand anxiety, its toleration and drainage into socially acceptable goals. False psychiatric notions are corrected and desensitization is emphasized, especially in connection with socialization. Then follows testing of reality in population. Here the inmate is encouraged to channelize his efforts for redemption, rather than seek the fortuitous "break", and, moreover, to compromise with frus-

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tration in the hope that he is prepared for the rehabilitative method administered by the custodial department.

CASE MATERIAL

The following cases will illustrate briefly the types of problems investigated and the results obtained, with special emphasis upon accessibility, abreaction, and suggestibility. The first case is presented in some detail to demonstrate the therapeutic approach. Only the major utterances are reported.

The Case of SS2

This subject insisted on Ward admission, threatening to kill the next inmate who called him "Baldy". He was anxious, disturbed, restless, seclusive, and sleepless

History: He is a 28 year old, white male, the eldest of four siblings, of average intelligence and 7th grade education. His financial and cultural backgrounds are marginal, and prior to commitment he maintained a common law relationship. He worked regularly as a common laborer. He was serving a sentence of 2½ years for violation of the Selective Service Act. The only physical abnormality he exhibited was alopecia totalis.

Diagnosis: Initial diagnosis was Simple Situational Reaction, but in the light of analytic findings Mixed Psychoneurosis, Organic Inferiority, and Simple Situational episodes were found more appropriate. Several days after admittance he volunteered for treatment.

First treatment (5 cc. pentothal): Tell me your troubles. About going into the Army. I feel I won't make good. I've been bald a couple of years. Typhoid. My nerves are on edge and when someone calls me "Baldy" I hit him. I can't go out and have fun. I'm ashamed. That's why I didn't go into the Army.

Second treatment (5 cc., three days later): I'm fed up. I want to stay on the Ward. No one makes fun of me here. *What is the meaning of baldness?* It's not the meaning, it's the feeling. I flare up. I feel people stare at me and make fun. I want to be alone. I'll kill the s. o. b. *Intelligent people sympathize with you. Why should you be disturbed by the unintelligent?* Yes, that's true. The officers don't say anything, but the lousy bastards—. *Why didn't you get a toupee?* I hadn't the means. I was scared to get a decent job.

Third treatment (5 cc., four days later): I see double, but I'm okay. I've been in fights as a child. They used to make fun of me. Even in school I'd smack them. Mom told me it was through typhoid. I lied to you. I wanted you to think I had hair so you would treat

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me. I've been bald all my life since I was a couple of years old. I have a common law wife and I feared the priest would see me. But she loves me. She's already married and can't get a divorce. I would marry her. I don't go anywhere. I keep my hat on when I work. When the guys get inquisitive, I fight. *Do you recall similar incidents during childhood?* In school I was laughed at by the kids and the teachers. One man teacher said he'd paint the world on my scalp, and that we don't need a globe. I fought him. I was like a leprosy case. *Tell me about the attitude of your parents.* I'd curse my father and mother. He'd kick the s - - t out of me. I wouldn't visit the family. At the maypole games they all laughed. I would beat the kids up and my father would beat me. I wouldn't tell him it's my hair. I threw a rock at my mother. I had a fine crop of hair at 2, I think. My mother shampooed my hair with some s - - t and it fell out. (At this point, subject began to exhibit some emotional reaction.)

Fourth treatment (5 cc., two days later): I remember, I remember—some guy took me for a ride on a motorcycle and he tried—to f - - k me. He promised me lollipops. I fought him. I never told anyone. Some old man took me to the movies and in the toilet the s. o. b. sucked me off. (Moderate tension.) I was scared and I let him have it. I was a mean kid. I wouldn't go out with the boys. I'd wear my hat in the movies. My father bought me a toupee but I threw it away. Everybody laughed. No girl wanted me. I couldn't get a date and had to go to a whore house. I sat in the restaurant with my hat on.

Fifth treatment (5 cc., two days later): My brother-in-law is no f - - - - g good. He says I'm lazy. He once tried to—I can't tell you! *Sexual?* Yes. (Moderate tension.) But I got away. I'll kill the next s. o. b. who tries to f - - k me or suck me. *Your problem is not merely being bald.*

Sixth treatment (5 cc., four days later): (For several days patient has been friendly with others on the Ward.) I dreamed of f - - - - g PP3. An installment collector tried to get my wife. I beat him up and also her. I'm worried he's still coming around. *Tell me about PP3.* If I were to be here long enough, I'd f - - k him and if he wouldn't, I'd fight him. It's f - - k or fight. In the dream a bearded man -. When I'd do something wrong as a child the bearded man would come and take me away in a sack. That's what my mother tells me. I remember an old woman—she used to make me suck her tits when my mother left me with her.

Seventh treatment (5 cc., ten days later): My wife hasn't written two weeks now. I'm afraid to go to population. I'm not sensitive here on the Ward about my scalp. (Suggestion about a trial in popu-

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lation meets with resistance.) No, they goose me there. (Scolded for a remark about fighting to get sexual gratification.) I didn't mean it.

Eighth treatment (5 cc., five days later): (Subject is much less sensitive.) *Something happened in childhood which is connected with baldness and makes you sensitive about it.* Once I took a liking to a girl. I wanted to f--k her. But she giggled when the boys pulled my hat off. (Moderate degree of tension.)

Ninth treatment (5cc., two days later): (Subject is quite relaxed on the Ward, friendly, but fearful of returning to population.) Doc, I remember I fell down in a hole when I was a kid. I had hair then. I wondered why I lost it after that. *Tell me about the hole.* I used to run around the foundation of a house. There was a watchman—an old man—he was bald—he chased me with a stick—to hit me. (These utterances were accompanied with rising tension.) Once he caught me—No!—No!—he took me to a shack—I cried. (Writhes about on the bed and beats the walls. Face is flushed.) He said he'd take me to a police station. I was afraid of Mom. He started to feel me. He touched me there—he took—my pants down. He said he'd lock me up if I told anybody. He—pet and touched me—my leg—No!—No, don't do it! No! Leg! Leg! That's it—my feet. *Go on! Talk!* Everything. Everything. *Talk!* My p--k, he kissed it. (Patient became rigid.) He grabbed me—took it in his mouth—I thought he'd bite it off—I screamed! (Patient speaks loudly.) He stopped and told me not to cry. I was 3 or 4 years old. He brought me ice cream. I went back. (Shouts.) If I got that s. o. b. now I'd kill him! To think that he did that to me! *Now that you're bald you think that others think that you're like him.*

Tenth treatment (3 cc., three days later): (It will be noted that less of the drug was required for narcosis.) I went to the show last night and the guys laughed at me. I felt they think I'm the kind of guy that f--ks with them. I'd have knocked the s--t out of them if it weren't for an officer there. I'm no c--s--. It reminds me of that man. I could choke him. (Rigidity and loudness of speech.) I feel much better. I have a guilty conscience. I did it. I did it with that guy. I let him suck me off. *Why did you stop?* He went away. *Tell me about the loss of hair.* It began to fall out afterwards. I thought being as I did it with him I'd become like him. Funny, friends I let alone—but strangers, I think they're trying to make a punk out of me. You know, the guys may be laughing only at my bald head. I don't want them to think I'm a punk.

Eleventh treatment (2 cc., the following day): I know my wife likes me. I used to worry about it. I'm in jail and I can't take care of her. Maybe she has someone else. I always felt, being bald, I'd

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lose her. I had a guilty conscience that I'm a punk. Well, I think I'll try population.

Comment: Utterances were spontaneous and the only strong suggestion given to him was to link up baldness with the personality who had violated his body. It is interesting to note that, in spite of the fact that these ideas were in his mind on one or two occasions under pentothal sodium, he later informed us that he had resisted giving expression to them. His abreactions were most satisfactory.

Result. Having arrived at the central emotional core, he showed considerable improvement. Examined from time to time for approximately 10 months subsequent to treatment, subject was found to be adjusting very well to population; he demonstrates no antagonisms, is no longer sensitive about his scalp, plans to purchase a toupee, and when called "Baldy" is not disturbed overtly. He eats and sleeps well and has gained 5 pounds.

PSYCHOPATHIC PERSONALITY

The Case of PP1

Patient was admitted to the Ward because of hostility towards a custodial officer and severe anxiety.

History: He is a 25 year old, white male, the 5th of 7 siblings, of average intelligence and 3rd grade education. Previous history was characterized by multiple juvenile offenses, unstable work record, poor financial and cultural background, divorce, and symptomatic alcoholism. He was given a 5 year sentence for desertion from the Army and car theft. When taken into custody he attempted to escape and assaulted an officer.

Diagnosis: Psychopathic Personality, Emotional Instability, Paranoid Personality, Symptomatic Alcoholism

Course of treatment: 6 sessions, averaging 6 cc.

Intimate utterances: The subject presented a vivid description of the primal scene which he interpreted as a severe beating to his mother. This resulted in intense Oedipus hostility with the wish to harm his father, reaching actual fruition during a family quarrel. He informed mother of father's extra-marital excursions and identified custodial officers with the father image. He admitted homoerotic interests.

Comment: Utterances were spontaneous, subject was not suggestible, and abreaction was severe. Oedipal hostility was transferred to the therapist and resulted in threatening the therapist's safety. Therapy was therefore discontinued although patient pleaded for more and himself suggested that he be placed in restraint during treatment.

Results: Slight improvements; able to think more freely about his utterances and now sleeps well. General unpredictability of be-

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havior necessitated transfer to a mental hospital, where he was reported adjusting satisfactorily five months later.

The Case of PP2

Patient was admitted because of hostility towards custodial officers and severe anxiety.

History: Subject is a 23 year old, white male, the 2nd of 3 siblings, of low average intelligence and a 7th grade education. He is of poor cultural and financial background and the father of a child by common law relationship. Past history notes juvenile delinquency, a poor work record, and frequent AWOL, although he managed to reach the rank of Sergeant in the U. S. Army. He was sentenced to a term of 3 years for the theft while in the Army.

Diagnosis: Psychopathic Personality, Emotional Instability, Symptomatic Alcoholism.

Course of treatment: 8 treatments, averaging 5.5 cc.

Intimate utterances: While in the Army the subject felt responsible for the accidental death of an acquaintance by not obtaining medical attention for him after an automobile wreck. Subsequently he saw the deceased's accusing face and felt the urge to run off from his unit. He feared telling the authorities of this episode. AWOL's followed and, being refused a transfer, he committed the theft. He described the primal scene with Oedipus hostility later transferred to custodial officers, making adjustment to institution difficult. Admits homerotism.

Comment: Subject had a satisfactory degree of abreaction, especially with respect to the accusing face. He transferred father hostility to the therapist with a threat on one occasion to do him bodily harm. He resisted continued therapy.

Result: Some improvement. He no longer sees the accusing face, sleeps well, and demonstrates a better attitude towards authorities. His appearance has improved, having gained 5 pounds, and he wishes Army induction. Improvement has lasted thus far 8 months.

The Case of PP3

Subject was admitted because of hysterical palsy.

History: He is a 20 year old, white, single male, the 2nd of 4 siblings, and of average intelligence. He is of poor cultural and financial background and reached the 3rd grade. Past history discloses multiple juvenile offenses and right lower extremity paralysis with exacerbations and remissions for a period of 5 years. He was sentenced to 18 months for stealing a car.

Diagnosis: Psychopathic Personality, Emotional Instability, Pathological Mendacity, Hysterical Anesthesia and Flaccid Paralysis of the Right Lower Extremity.

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Course of treatment: 3 treatments, average dose 5 cc.

Intimate utterances: Subject claims he murdered his brother during a violent quarrel and insists that his brother's "spirit" visits him during the night and threatens him with death. He experienced a violent reenactment of the scene in which his brother was murdered.

Comment: With the first treatment, suggestion was effective in relieving subject's palsy. Further therapy was attempted but subject was unreliable and refused to continue. Originally he insisted he was paralyzed for 8 years, continuously, but when confronted with the fact that no signs of atrophy are evident, he admitted that its duration was on and off for a period of 5 years. Abreaction was severe.

Result: Hysterical palsy and anaesthesia cleared with one treatment and patient is now recovered for 15 months. Substitutional transitory hysterical and malingering signs appeared shortly after dismissal from the Ward, but for the last 5 months he has been adjusting satisfactorily with supportive psychotherapy.

The Case of PP4

Subject requested admission because of severe anxiety.

History: He is a 20 year old, white, single male of average intelligence, 8th grade education, marginal financial and poor cultural background. He is the eldest of 3 siblings and was involved in several juvenile offenses. He was dishonorably discharged from the Navy, used an alias to enlist in the Army, went AWOL several times, and attempted suicide on 3 occasions. He was sentenced to a period of 2 years of penal servitude for stealing an auto.

Diagnosis: Psychopathic Personality, Emotional Instability, Homosexuality.

Course of treatments 16 treatments, average dose 7.3 cc.

Intimate utterances: Subject revealed the primal scene with subsequent development of hostility against the father and incestuous urges for his mother. He was later distressed by father's extra-marital indulgences and informed his mother. He identifies all females with mother during sexual contact and is unable to satisfy his appetite. Hence he is driven to men and in the Army he consorted with his unit officer. When this became known he requested transfer and upon denial he escaped through crime. Homosexuality is the cause of suicidal attempts.

Comment: Spontaneous, compulsive speech with transference of Oedipus hostility onto therapist and a threat to trounce him on one occasion.

Result: Subject improved considerably, evidencing better insight and improved attitude towards officers and his future. He slept well, worked satisfactorily, and had a good appetite for 3 months, after

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which time he again suffered the conflicts of homosexuality. Upon revealing actual incest with his mother, with further therapy he improved considerably and has remained so for two months. Further follow-up not made.

The Case of PP5

Subject requested treatment because of repeated episodes of confusion and anxiety.

History: He is a 33 year old, white male, the 6th of 10 children, of average intelligence and poor cultural and marginal financial background. He reached the 8th grade and presents a lengthy juvenile history. Following separation from his wife, his 3 children were placed in a home while he took himself a paramour. He was committed for 2½ years for violation of the Selective Service Act.

Diagnosis: Psychopathic Personality, Emotional Instability, Nomadism, Paranoid Personality with Episodes of Depression.

Course of treatment: 35 treatments, average 5.2 cc.

Intimate utterances: Subject revealed a probably fantasied violation of his person during childhood by an elderly woman. He relates homoerotic experiences with his brother and incest with his sister, both with intense fear of father. Admits his aggressive behavior and suspiciousness are to cloak a homosexual appetite. He asserts that all psychopaths are basically homosexuals.

Comment: Utterances were spontaneous and dreams were frequent, but he was not open to suggestion. On one occasion he expressed severe abreaction with exhibited transferred hostility towards the therapist.

Result: Much improvement following revelations and abreaction. He has rejected his paramour and has decided to assume full responsibility as father and husband. He was dismissed as no longer anxious, which pattern has continued now for a period of 10 months; he socializes with his fellow inmates and eats and sleeps well.

The Case of PP6

Subject was admitted because of a suicidal attempt.

History. He is a 28 year old, white male, the eldest of 4 children, widowed, of above average intelligence and poor cultural and financial background. He completed 2 years of agricultural school and obtained a Sergeant's rank in the U. S. Army. Multiple juvenile offenses and alcoholism are recorded. He was sentenced to 12 years, reduced to 5, for setting fire to a building on a military station.

Diagnosis: Psychopathic Personality, Emotional Instability, Nomadism, Homoerotism, Pyromania, Enuresis, Severe Acne Vulgaris, Acne Rosacea.

Course of treatment: 29 treatments, average dose 6 cc.

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Intimate utterances: He expressed strong, ambivalent, incestuous desires for his mother who is a prostitute and is suspiciously homosexual. Reveals he had large breasts which were amputated. Wishes to be assaulted homosexually but when in authority gives subordinates a hard way to go in order to cloak this wish. He fears all women as mother surrogates and believes he killed his wife "accidentally" in a car wreck. Pyromania is linked to being locked in a closet by mother while she engaged in sexual activities and to free himself he set the closet on fire. He recalls vividly being violated at the age of 4 by an adolescent female cousin.

Comment: Subject resisted therapy for fear of returning to population where he felt he would have to yield to sexual advances. Utterances were spontaneous and patient was moderately suggestible at times. Abreaction was severe on one occasion when he tossed a chair at the wall.

Result: Subject was depressed for one day after dismissal but for the last 3½ months is friendly, is able to curb his homosexual appetite, and regards the future hopefully. He has gained 11 pounds and his acne eruptions have improved considerably.

The Case of PP7

Admitted for treatment because of multiple disciplinary violations.

History: Subject is a single, 23 year old, white male, above average in intelligence, and the 2nd of 4 siblings. He had a 5th grade education, presents a juvenile record, dishonorable discharge from the Army, and reveals alcoholism. Cultural background is poor and financial status marginal. He was sentenced for 2½ years for auto theft.

Diagnosis: Psychopathic Personality, Emotional Instability, Nomadism, Pathological Mendacity.

Course of treatment: 20 treatments, average dose 4.2 cc.

Intimate utterances: Intense Oedipal hostility and transfer to surrogates. Stole from father to take his power away. While speaking of sexual escapades subject experiences abdominal pain. This is traced to being kicked by his father and paramour when the subject saw them in sexual contact. Patient also saw his sister masturbating and expressed a strong desire for her sexually. He admits homoerotic experiences.

Comment: Abreaction is satisfactory. On one occasion he threatened to strike the therapist. Moderate degree of suggestibility.

Result: Improved institutional adjustment. Subject displays a better attitude towards officers, his appetite is good, and he has gained 8¼ pounds. He is able to curb homoerotic drives and associates well with fellow-inmates. No follow-up.

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PSYCHONEUROSES

The Case of PN1

Subject was depressed, tearful, and suffered aerophagia.

History: A 44 year old, white, married dental mechanic who has two children. He is of average intelligence and of fair cultural background. He is the eldest of 7 siblings and has a good work record. He was once arrested for practicing dentistry without a license. Having conspired to aid and abet others to avoid induction, he was sentenced to 18 months.

Diagnosis: Reactive Depression with Hysterical Aerophagia, Neurotic Personality with Compulsive Drives.

Course of treatment: 3 treatments, average dose 5 cc.

Intimate utterances: He expressed the need for money to provide family with luxuries and to set aside a sum for his son's medical education which had been denied the subject. Offered a "secret" that he had turned government witness.

Comment: Spontaneous utterances of guilt, intense abreaction, but resistive to suggestion.

Result: Recovery from acute symptoms, good institutional adjustment for 3½ months, after which time he was released.

The Case of PN2

On admission subject was depressed, lachrymose, suicidal, and seclusive.

History: He is a 42 year old, white male, the elder of 2 siblings, above average in intelligence, and of good background. He had a high school education, is married, has 7 children, and managed to provide for his family. Counseled and advised registrants for Selective Service to evade induction and as a result received a 12 year sentence.

Diagnosis: Reactive Depression, Suicidal.

Course of treatment: 5 treatments, average dose 5 cc.

Intimate utterances: Self-recrimination for large family because of his strong sexual drive. He had enlisted in the Navy in order to satisfy his patriotic urges, but was unable to provide for his family thereafter. Finally, he expressed an extra-marital experience in connection with present offense.

Comment: Spontaneous utterances, severe abreaction, and moderate suggestibility.

Result: Recovery from acute symptoms. He has adjusted well to institution now for 6 months.

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The Case of PN3

Subject was admitted because of acute anxiety and claustrophobia.

History: He is a 24 year old, white male, the 2nd and only boy of 3 siblings, of average intelligence and poor cultural and financial background. He completed elementary school, is married, and has 2 children. Previous history reveals a lengthy juvenile record, and while on parole from an institution he was urged to enlist in the Army. He was sentenced to 10 years for desertion and larceny.

Diagnosis: Mixed Psychoneurosis, Enuresis, War Neurosis, Acne Facialis.

Course of treatment: 20 treatments, average dose 5.2 cc.

Intimate utterances: Subject stated he deserted because he was unable to face war horrors and because his unit knew of his criminal record and rejected him. He witnessed the primal scene at the age of 6 and, subsequently, his mother's extra-marital excursions. Following this, he attempted incest with sisters and was punished. He insists this created a fear of women as well as a fear that he would turn to homosexuality for sexual gratification. He admits that he had often wished that he were a woman. He dreams of fellatio with mother and sister, is unable to eat meat because of its association with penis.

Comment: He abreacted battle experiences and neurotic memories satisfactorily. Wife visited and commented that he had never looked better since she knew him.

Result: Much improved. Acute pattern has subsided. It is interesting to note that acne facialis has improved and subject is eating meats and has gained 4 pounds. He adjusted most satisfactorily to institutional demands for 3 months when he was notified that his wife wished to sue for divorce. He weathered this blow satisfactorily.

The Case of PN4

Subject was admitted because of confusion, amnesia, and paranoid ideation.

History: He is a 21 year old, single Negro, of borderline intelligence and poor cultural and financial opportunity. He is the 2nd of 4 siblings, illiterate, and has had only a 1st grade education. He was sentenced for 25 years of penal servitude for robbery and assault of a railway mail clerk.

Diagnosis: Hysterical Confusion, Amnesia, Hallucinations of Hearing in an Emotionally Inadequate Individual.

Course of treatment: 16 treatments, average dose 5.1 cc.

Intimate utterances: Persistent denial of guilt. He relates that he had been advised to admit his offense and implicate his co-defendant by a fellow prisoner at the local jail in order to obtain a minimal

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sentence. Present attack brought on by a dream of sexual relations with his cousin, which to him is incest. He viewed the primal scene with oedipal hostility, fearing that his mother was being beaten. Thereafter was afraid of women. Announced that he feared homosexual assault in the local jail and finally admitted the same fear in his present surroundings.

Comment: A superstitious, illiterate person who is preoccupied with voodooism and must face a 25 year sentence. Little suggestibility and only fair abreaction

Result: Recovered. Patient is lucid, memory is good, and no longer is he paranoid or disturbed by hallucinations of hearing. He is well adjusted to institutional demands now for a period of 8 months.

SCHIZOID PERSONALITY

The Case of SP1

Subject requested therapy for hysterical tic and anxiety.

History: He is a white, single, 25 year old male of superior intelligence with a fairly good cultural and financial background. He is the younger of 2 siblings and a high school graduate. He was sentenced to 14 years for writing a threatening letter to a railway company demanding \$50,000 on the threat of wrecking a train.

Diagnosis: Schizoid Personality, Hysterical Head Tic, and Anxiety State.

Course of treatment: 13 treatments, average dose 5.4 cc.

Intimate utterances: Described homosexual advances made to him in a previous institution and his compensatory, aggressive behavior to fight them off. He fears degeneracy and protests he is a man and not a "fairy". Several years before commitment he quit his job because men spoke "dirty and of fairies". He associated the head tic, in the horizontal plane, with the denial that he was a homosexual.

Comment: Bitterly resistive, but he verbalized the cause of the tic with little abreaction. He insisted he was well.

Result: The tic subsided for 2 weeks but has recurred and with it came the flat denial of its sexual meaning. He refuses continued therapy, but despite the tic is no longer anxious and claims a comfortable adjustment to the institution now for 6 months.

The Case of SP2

Subject was admitted because of seclusiveness and refusal of work assignment.

History: An illiterate, Porto Rican male, 27 years of age, of borderline intelligence, 5th grade education. He is the eldest of 3

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siblings, separated from his wife, and the father of 3 children. He was sentenced to 3 years for having violated the Selective Service Act.

Diagnosis: Schizoid Personality, under Observation for Dementia Praecox.

Course of treatment 2 treatments, average dose 3.5 cc.

Intimate utterances: Marital discord because of his introversion. Feels uncomfortable in the company of others but denies abnormal ideation.

Comment: Examined with the aid of an interpreter, he displayed spontaneity and was moderately suggestible.

Result: Adjusting well to institutional assignment for 5 months now. Basic personality is unchanged and psychosis temporarily excluded.

SIMPLE SITUATIONAL REACTION

The Case of SS1

Subject requested treatment for anxiety and hostility towards the inmate body.

History: A 24 year old Negro with poor cultural and financial opportunities. He is the 2nd of 3 siblings, of average intelligence, and has had 3 years of high school. He is separated from his wife who has borne him 3 children. He was sentenced to 3 years because of failure to report for induction.

Diagnosis: Simple Situational Reaction in an Aggressive Personality.

Course of treatment: 7 treatments, average dose 4 cc.

Intimate utterances: Intense Oedipal hate of father and surrogates. Admitted actual incest with mother after the father had left the family, also homosexual practices with brother. Spontaneous recognition of why, when called a m - f - (a gutter reference to incest with mother) he becomes enraged and uncontrollable. Also understands failure to adjust maritally, tracing this to identification between wife and mother and incestuous guilt.

Comment: Delayed compulsive speech with excellent abreaction.

Result: Full recovery. Excellent behavior in institution for 3 months whereupon he was discharged to the Army.

SCHIZOPHRENIA

The Case of DP1

Subject was admitted because of irritability and paranoia.

History: A 28 year old, single, white male of average intelligence and poor cultural and marginal financial background. He has had a 7th grade education. He is the 7th of 10 siblings, 3 of whom are

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schizophrenics. Following a gonorrheal infection contracted 3 years ago, he became involved in many shady practices and on one occasion assault and battery. He was committed for 10 years because of armed robbery of a bank.

Diagnosis: Schizophrenia, Paranoid Type.

Course of treatment: 8 treatments, average dose 4.2 cc.

Intimate utterances: Repetitious insistence that he is a man and wishes to prove it by a welding assignment at which he is proficient. He is irritated by sexual chatter in population and suspects that homosexual references are leveled at him.

Comment: Resistive, not suggestible, and unable to abreact.

Result: Unimproved. It is noteworthy, however, that narcoanalysis did not aggravate his condition.

DISCUSSION

Pentothal narcoanalysis may be evaluated from several points of view in connection with the foregoing observations. Its major contribution lies in the promise of providing analytical therapy for individuals who ordinarily fail to satisfy the intellectual, cultural, and character reliability requirements for orthodox analysis. The majority of patients in this series were deprived of these essentials; one believed strongly in voodooism and two were of borderline intelligence.

To a man, the group responded to pentothal with increased accessibility and, with two exceptions, one paranoid schizophrenic and one schizoid personality (SP2), with hypermnesia. SP2, however, became sufficiently accessible to exclude psychosis. Moreover, pentothal induces the added advantage of euphoria. Unsolicited comments, such as, "This gives me a pleasant feeling—You are the only man I opened up to—It makes me say things I shouldn't—It makes me want to talk—I'll tell you a secret—I can go back very far with this drug," are therefore noteworthy. It may be assumed, on this basis, that by promoting euphoric accessibility pentothal prepares the patient for analysis.

Whether the remarkable intimate utterances obtained by narcosis are valid constitutes a serious problem for research, especially in view of the generally recognized character unreliability of the group studied. Still, the nature of their dis-

closures, humiliating and self-debasing as they were, would suggest that they are reliable. Even the question of whether these expressions are fantasies is of no moment, since it is recognized that fantasy is as damaging to the personality as fact. Practically all patients in this study exhibited confidential dependence upon the therapist, baring secrets which are ordinarily kept from others, certainly from a prison official. These subjects, especially the psychopathic personality, would not consciously dare to admit intimacies indulged in or observed, or mention the names of homoerotic partners (which occurred in four instances), all of which would be in violation of the inmate code. Moreover, the psychodynamic material that was revealed promises a fertile opportunity for research in criminal motivation. The primal scene, incestuous guilt, and Oedipus hostility were all vividly and spontaneously recalled, especially by the psychopathic personality. Sexual violation in childhood was also recovered and practices of homosexuality frankly admitted. It is interesting to mention in passing the conclusion of PP5 that "all psychopaths are homosexuals" who try to cloak sexual deviation by aggressive behavior. It is a credit to pentothal that so little time was required to obtain information which would have taken months, if not years, to appear under orthodox methods. Undoubtedly, given the opportunity, several of these individuals would have talked past the point for a lengthy period of time about their rich and dramatic experiences had not significant buried complexes appeared. Hence, narcoanalysis is suggestively time-saving.

Abreaction in depth therapy is obviously important. Ordinarily one would surmise that the sedative effects of pentothal would interfere with abreaction. However, our experience certifies to the contrary. As a group, the psychopathic personality abreacted severely and tended to transfer a pronounced father hostility upon the therapist with the threat to do him bodily harm. Under these circumstances, deeper narcosis was necessary to induce amnesia and delay the negotiation of unconscious material too fresh for conscious assimilation.

Unfortunately, in addition to a severity which endangered the security of others as well as the writer, PP1's abreaction was delayed and unpredictable. Hence it was decided to interrupt treatment despite his plea for more and to "put me in a strait-jacket because it is doing me good". PP2 faced his fictive accuser threateningly; PP3 reenacted a violent quarrel with his brother which resulted in the latter's death; PP5 rolled off the bed in horror when he uttered the conclusion he is a "queer"; and PP6 tossed a chair at the wall while speaking of his mother's sexual excesses. Psychoneurotics cried bitterly during expressions of self-recrimination. Those classified as Simple Situational Reaction abreacted satisfactorily. The remainder of this group failed to abreact significantly, a fact which may be attributed to emotional inadequacy.

It was also observed that suggestion was greatly facilitated by pentothal in the treatment of gross conversion disorders. PP3 recovered from hysterical paralysis and anesthesia in one session and PN1 yielded aerophagia in two sessions. On the other hand, interpretive suggestion, which was used freely with PN4 to break through resistance and stimulate him to speak, was flatly rejected. SP1 refused to recognize the sexual meaning of head tic early in the course of treatment despite strong suggestion. These reactions tend to indicate that psychic censorship prevails despite narcosis and that invalid analytical interpretation of inner psychic conflicts cannot be engrafted by suggestion, however strong it may be. SP2, however, prompts the conclusion that interpretive suggestion is acceptable when the psyche is "prepared." Fear, in turn, could be controlled to some extent by soothing suggestion in connection with abreaction.

Passing mention may be made of the tendency of several patients to dream more freely during and after therapy than ever before. Most dreams were surprisingly simple to interpret and indicate a more readily accessible unconscious obtainable in a short period of time. Reference may also be made to the psychosomatic improvement of two cases of severe acne vulgaris, one of whom also had acne rosacea.

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The foregoing observations credit pentothal narcoanalysis with usefulness, certainly as a research instrument. But despite our original interest in productivity alone, some interesting results were observed. In this connection, it must be borne in mind that treatments were restricted both as to duration (one-half hour) and as to number of sessions. Moreover, several patients refused continued therapy and one abreacted so intensely that therapy was considered prohibitive. In addition, no rewards for their pains in yielding neurosis could be offered, unless the return to population for penal servitude can be so interpreted. Given due consideration for the interruption of treatment was the possibility of promoting infantile dependence and the apprehension of returning to population by prolonged hospitalization. These dangers and the possibility that lengthy treatment may result in analytic preoccupation with rejection of reality were factors to be dealt with. In general, however, subjects were dismissed when to all appearances the emotional core had been enucleated and they had developed sufficient grasp of unconscious motivation to enable them to adjust by testing reality with new-found insight. Judging, finally, from the disappearance of acute symptoms, the appearance of good appetite, weight gain, diminished sensitivity to frustration, and a more wholesome attitude towards officers and fellow inmates, certain tentative conclusions can be drawn. The results are tabulated:

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	Unimproved	Improved	Much Improved	Recovered
Hysterical Palsy (with Psychopathic Personality)				1
Hysterical Amnesia				1
Acute Reactive Depression				2
Simple Situational Reaction				1
Psychopathic Personality		4	2	
Mixed Psychoneurosis			1	1
Schizophrenia, Paranoid type	1			
Schizoid Personality		2		

Other elements contributing toward improvement should be recognized although they appear to be of lesser importance than actual treatment. The retreat from population into the sheltering atmosphere of the hospital, with diminished responsibility, and medical attention which gratifies affect-hunger, are obviously helpful. Of significance, too, once rapport is fixed, is the inmate's fear of relapse because it may discredit the psychiatrist. In this connection, we are in agreement with Stekel who insisted that successful treatment rests upon maintained positive transference, throughout life if necessary¹⁷.

CONCLUSION

Pentothal sodium narcoanalysis appears to have gone beyond the stage of ballyhoo to that of objective evaluation; but it has yet to reach final acceptance or rejection. As with other drugs, pentothal can be evaluated from the point of view of need, safety, practicability, and value. There is unanimity of opinion among many workers that a chemical substance is needed to aid psychotherapy by inducing a true hypnotic state, with euphoric relaxation, to eliminate resistance and to promote hypermnesia, so that carefully guarded secrets can be elicited with minimal interpretation and suggestion. This substance must be widespread in adaptability, sure, reliable, safe, and must permit any physician to arrest and maintain the patient's full attention and dominate his feeling, thinking, and actions. Actually it should enable the patient, despite intellectual and educational deprivation, to brush aside screen memories for a quick approach to the unconscious core, and facilitate abreaction.

Judging from our experiences with 16 extraordinarily resistive individuals, prisoners whose situation is unalterable and who receive no reward for yielding neurotic conflicts, pentothal is a step in the direction of satisfying these demands. It holds promise of being a prepotent instrument for research in penal psychiatry, and a time-saving analytical psychotherapy which will prepare the inmate for institutional rehabilitation. Information obtainable in a few hours is equivalent to that obtained by other methods in months, if not years. Moreover

there is adequate abreaction. Finally suggestion is expedited to overcome gross conversion disorders.

Pentothal narcosis has certain advantages over ordinary hypnosis. The technique of administration is easily learned, practicable and eliminates the need of a skillful hypnotist. Therapy commences with the first injection and requires no period of training to promote a satisfactory hypnotic state. Students can be present to observe from the very beginning of analysis, since their presence is not distracting to the patient under the drug. Psychotic, confused, and fearful patients, as well as the malingerer and those of low intellectual endowment, can be treated. Moreover, it is our impression that the patient is much less dependent upon the therapist than is ordinarily found in hypnosis, and to all appearances he is less suggestible. Of the disadvantages, one easily overcome by education is the subject's belief that, since a drug is employed, his disease is physical in nature. Of course, the use of pentothal is not without some danger, but if administered skillfully it is quite safe. Furthermore, as with hypnosis, there is an air of mystery surrounding the whole procedure, which is, however, minimal with narcosis. Finally, pentothal cannot be used with obese individuals with fragile or inaccessible veins.

Despite the value of pentothal, it must be emphatically declared that it is no substitute for analysis, for by no stretch of the imagination does it eliminate the need for "delicate psychologic technique"⁷, since buried complexes must be brought well within the scope of consciousness and thoroughly assimilated. Pentothal facilitates analysis by changing the subject's attitude toward the analyst to one of confidential dependence, and with promoting hypermnesia.

In summary, hypnosis can no longer be rejected "as a procedure impracticable to 60% of patients and 99% of doctors"¹¹ now that its induction is possible by narcosis. Moreover, narcoanalysis shows promise of offering an alternate analytic therapy for psychoanalysis where the pressure of cost and time are important.

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THE MEANING OF PUNISHMENT

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Ever since men first attempted to band together in some kind of communal life they have been faced with the problem of how to deal with those among them who violated the self-imposed laws of the group and thus became a threat to the others. Civilization may be said to have dawned when a number of men agreed to restrict their individual privilege of unlimited aggression and predatory rapacity against others, and united together in strength superior to that of any individual or rebellious minority. For this union and voluntary forfeit of some of their "liberties" men gained a much greater degree of safety, for no longer were they individually at the mercy of the aggression of other stronger individuals. The combined strength of the united group stood ready to cope with the individual who broke the group's laws. From primitive beginnings of this sort has developed our highly complex present day social existence.

Obviously, if every member of the group adhered to the group's laws there would be no problem of crime and punishment; but from the beginning this has never been so, and one is driven to believe that it can never be so. The motives impelling men to carry out actions in pursuit of their own individual impulses of aggression, predatory acquisition, and bodily satisfactions, are so powerful instinctually and so frequently reinforced by competitive, frustrating clashes with the desires of others, that there likely will always be transgressions of group laws; and, as in the beginning, group strength will have to be brought to bear on the transgressors to preserve the communal safety. The only question is in regard to how the strength of the group shall be brought to bear on the non-conforming offenders. Throughout history the group authority has reserved the right to punish the offender, and, although

the laws and punitive methods have undergone enormous evolution as civilization has progressed, the impulse to punish is still the prime motivating force directed against violators of the laws.

The problem is far wider in its scope than the field of penology. The aggressor nations who precipitate world wars pose many of the same problems in the world community that individual criminals pose to local, state, and federal governments. What shall be their punishment? What kind of treatment will be most likely to deter them and others from similar actions in the future? Can they be "reformed" or reeducated? Shall it be a "hard" peace, *i.e.*, a peace of vengeance, or a "soft" peace, a peace directed toward rehabilitation? And if the latter, what assurance can the law-abiding, peaceful nations have that the aggressors, when rehabilitated, will not commit further aggressions endangering the safety of the world group of nations? At the level of international relations the problem of punishment is tremendously complicated by a network of economic, political, sociological, geographic and ethnological factors, and it is not proposed in this article to discuss, but only to call attention to, the question of punishment in dealings between nations.

The area in which the meaning of punishment can most readily be studied is that of child-rearing. Furthermore, the best hope of prevention, not only of crime but of mental illness of all kinds and even ultimately of war itself, lies in the application of our best scientific knowledge of psychology to the task of the bringing up of children. Let us postulate an ideal state of world civilization in which every adult would be able to utilize all of his aggressive energies in constructive activities for the common good, and would be capable of rearing his children with exquisite psychological understanding, correctly balanced indulgence, and firm discipline, into mature, well-integrated adults. In such a world, the Utopian goals of justice, brotherhood of man, an economy of plenty, and an absolute minimum of violence and crime would be attained. However, one hears immediately the clamor of objection to

this formulation: the state of civilization postulated is impossible of realization, and is only a theoretical definition, tailor-made to exclude all the realities of sordidness, self-seeking proclivities, hateful retaliation, and insoluble conflicting interests which abound in the world. And, anyway, where could we start with such a group of mature, perfectly trained parents? Who would have reared *them* from childhood into such paragons? And what about the millions of incompetent, ignorant parents over the face of the earth who are constantly rearing new recruits to the ranks of the criminals, psychopaths, and other disturbers of the peace?

Mindful of all these realistic and compelling criticisms, I submit the proposition that the progress of civilization from the beginning has been made by slow, tedious, painful steps against just such cynicism. We have come up from brutes, and while there are still many brutes among us, and considerable brutishness in all of us—albeit somewhat more refined and subtle than it was some centuries ago—there is hope that we can still progress, over a few more thousand years, to at least a closer approximation of the ideal state postulated; and the most effective progress toward this goal can be made through psychologically sound rearing of the new generations from birth to adulthood. If we were to spend for psychological research and education even one percent of the amount World War II has cost the gains would be magnificent beyond our wildest dreams.

In a sense, every child who grows up from helpless, self-centered, gratification-craving, irresponsible infancy into psychological and physical maturity—with all that the term maturity implies in respect to sublimation of aggressive energy into productive channels, endurance of frustration, consideration of the rights and needs of others, and acceptance of responsibility—treads in his growing up the path civilization has trod from its beginning until the present level of cultural attainment. While this civilizing process of child rearing is going on, the child is influenced for better or worse by every attitude shown it by its parents and educators, and every item of

discipline, every display of intolerance or of affection or of hate forms a part of the mold into which the child is being cast. The meaning of punishment in the scheme of child-rearing is only one aspect of the process, although a very important one; for the amount, kind, and appropriateness of the punishment, along with the attitude of the punisher, serves as a criterion of the psychological maturity of the parent, and comprises one of the most critical influences in the child's development.

Punishment and discipline are not synonymous, although our psychological and cultural bias toward retaliation, meeting aggression with counter-aggression, and discharging our own tension when provoked by others, has tended to make us think of discipline in the terms of punishment. Discipline means mental and moral training and education of a follower by a leader; punishment, as a training measure, may or may not be involved. It is significant, however, that such words as discipline, parental control, authority, law enforcement, and so on, all seem to connote punishment to us. Our language is full of idioms and sayings which exemplify this bias. We say, "Spare the rod and spoil the child", "Let the punishment fit the crime", "tit for tat" and "an eye for an eye and a tooth for a tooth". "A burned child dreads the fire", "It serves him right", "He got his just desserts", and a host of other such expressions which indicate that we regard punishment for an offense as proper and not even to be questioned. We speak of a law as being unenforceable unless it "has teeth in it", *i.e.*, unless it carries a specified penalty for infraction, and sets up machinery to implement the penalty. We know, however, that for most of us who are law-abiding, responsible adults no enforceable law is required to deter us from committing criminal acts. If all such laws were repealed we would still conduct ourselves as we did before. Considerations of the respect of our friends and of our own self-respect, and of our having to live with our own consciences would deter us from robbery, mayhem, rape, and murder. Hence, it must be that laws and penalties are directed against another class of per-

sons, those who are not thus deterred by an inner code of restraints or by considerations regarding the esteem of others. We say that such people do not understand anything but force, *i.e.*, punishment. But our experiences with habitual criminals, the best examples of such a class of persons who are presumed to require laws and penalties, is that they do not understand, or respond to, punishment either. Could it be that a process of child-rearing and education which is based on the punishment idea of discipline defeats its purpose and merely perpetuates the vicious circle of aggression and retaliation, spite and revenge? Perhaps we have somehow missed the mark, and continue to miss it, in presuming that punishment serves any purpose in influencing the offender except to provoke him to further aggressions. Our theories that punishment forces him to "pay his debt to society", serves as a deterrent to further offenses, and educates him to perceive "the error of his ways" and to believe that "crime does not pay", may all be high-sounding rationalizations of our own vindictiveness; while we remain blind and obdurate in regard to the possible advantages of other kinds of discipline and treatment because of some inner need to retaliate against those who do not exercise the same kind of restraint over aggressive impulses that we do.

Let us examine how these considerations apply to child-rearing. If we are competent to be parents at all, which many of us are not, we should be aware of several fundamental psychological observations:

1. That the infant is a creature of intense physical and emotional cravings which are completely selfish and of which he desires immediate gratification.

2. That in the beginning these needs for nourishment, warmth, comfort, affection, and security must be met completely, and that the minimal needs and rights of a child in these respects must be fulfilled throughout childhood.

3. That as the child develops and his desires become more complicated he must inevitably be frustrated by the denial of certain of his wishes, and that this frustration will evoke angry resentment and disobedience of the prohibitions.

4. That not only will his own wishes to continue being helpless and dependent and to be immediately gratified have to be frustrated, but that he will have to be taxed with expectations that he become gradually more self-sufficient, and even that he do things for others.

5. That if all his desires are gratified and nothing is expected of him, no discipline at all is being brought to bear in his rearing, and he will never mature emotionally or be able to fit into society, but will become "spoiled", self-centered, inconsiderate, irresponsible, and wind up as a neurotic, psychopathic, or delinquent adult.

6. That if any necessary frustration is to be done, two main avenues of influence may be used:

a. He may be forced into submission, because he is weak and his parents are strong, by intimidation and punishment, the outcome then depending on his constitutional vigor, the techniques he may be able to develop to circumvent the parental authority, and the consistency of the parental demands. He may become a submissive, timid, over-good child, fearful of all authority, unable to assert himself or compete with others, or he may become tricky, dishonest, defiant, and spiteful and very likely delinquent as he progressively escapes the redoubled attempts of his parents at intimidation and suppression.

b. He may be gradually and consistently educated and disciplined ("educate" from the Latin "educo", to lead out; "discipline" from "disciple", to follow a leader, to be mentally and morally trained in following and identifying with a leader) by the affection of the parent and his wish to retain this affection. Necessary frustrations are explained to him, and he is led to recognize and accept greater future values to be gained by foregoing immediate gratifications of his desires. Unacceptable behavior is met with firmness and insistence that it will not do, with explanations again as to why it is unacceptable. Actual punishment occupies a very small part in such rearing because it is so seldom necessary; and on

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those infrequent occasions when it is necessary, it is administered in the form of requiring appropriate restitution to the persons harmed by his offense, or, if that is not possible by the nature of the offense, by restrictions of privilege which are as directly related to the offense as possible. Firmness of control is established by parental example, by the tone of the voice, or by a firm grasp on his arm while "laying down the law" instead of by threats, bodily punishments, and unnatural deprivation of a meal or of some other unrelated pleasure. If this policy is carried out consistently in an atmosphere of secure affection, the child develops his own inner controls out of identification with the parents and out of a wish to retain their affection and esteem. The end result is a psychologically mature, responsible citizen.

According to the last, and recommended, principle, punishment has little place in child-rearing, and the child's development proceeds along to a level of personal responsibility where laws and their penalties are scarcely needed for him as deterrents. But what of those adults who were brought up by intimidation and punishment? For them it may be literally true that they do not understand anything else because they have had no experience with anything else. First their parents and later the teachers and community law enforcement authorities have met their aggressions with retaliation, doubled and redoubled as various punishments proved to be no deterrent to further anti-social acts. Not only are they not deterred by punishment, but sometimes they seem actually to seek it, exploit it, defy it, and challenge its power to affect them—all of which manifestations are stupidly met by authoritarian persons with further retaliative efforts of greater severity in the form of longer terms in prison, harder labor, more wretched rations, and solitary confinement, as if society would not tolerate any challenge against the ability of its punitive power to crush rebellious aggressiveness. It seems that our penal methods have not caught up with our scientific knowledge, inadequate as it is yet in many respects, concerning the under-

standing and handling of human problems. This cultural lag must be partly due to the amount of inertia to be overcome in changing such widespread structures as criminal law, criminal courts, prisons, and reformatories have come to be; but it must also be largely due to our inherited and psychologically conditioned tradition of retaliatory punishment.

Psychiatrists certainly make no claim that they can treat and cure all criminals. When confronted with particular cases they often are forced to admit that nothing in the way of treatment techniques that psychiatry has yet been able to devise would have much influence on an habitual criminal whose character distortion stems from earliest childhood. They and the sociologists, criminologists, and other enlightened citizens do, however, point out that in the evolution of penology the following stages and trends can be noted:

1. A primitive stage of cruelty toward offenders in the forms of torture, maiming, death by beheading, boiling in oil, etc., inflicted upon the accused with no adequate safeguards to establish his guilt and no considerations of his personal responsibility or irresponsibility for the act committed, often interwoven with religious zeal which made non-conforming beliefs a punishable crime; severe, even capital punishments for trivial offenses; and ignorance of the question of responsibility so great that animals or even inanimate objects were destroyed because they had been involved in punishable acts.

2. Reform in respect to the right of the accused to a fair trial, and to be presumed to be innocent until proved guilty.

3. Abolition of cruel and inhuman punishments, and an attempt to make the penalty fit the offense.

4. Recognition of the doctrine of responsibility, dating from the McNaughten case in England, in 1843, which exempted the mentally sick from the punishments prescribed by law for their particular offense.

5. A growing tendency in criminal practice to punish the individual rather than to punish the act.

6. Prison reforms in regard to segregation of prisoners with respect to their prison records, their attitudes, and their

prospects of rehabilitation, so that good behavior is rewarded, and cooperative prisoners can work and play inside the prison in a program of reeducation.

The over-all trend, as represented by these progressive, if not exactly chronological, steps, is seen to be away from primitive, cruel vindictiveness toward a more just appreciation of the human problems and values involved in the conflict between the criminal's tendencies and the safety of society. The next step should be in the same direction, and should consist of individual examination, diagnostic and prognostic appraisal of each offender by psychiatric techniques, followed by recommendations for a program of *treatment* rather than of punishment. Such a treatment program would have two main objectives: (1) The protection of society from the aggressions and depredations of the offender for as long a period as was deemed necessary, after scientific study and continued scientific observation. This would certainly mean an indeterminate "sentence" for each offender, rather than a set term of confinement stipulated for an offense according to the gravity with which the offense was regarded. This would not mean the abolition of prisons and confinement in prisons, but would imply regarding them and utilizing them as isolating institutions for society's protection. (2) The attempt to salvage and rehabilitate every offender by fitting him into a program of work, recreation, psychiatric treatment (if indicated), reeducation and all influences that could be brought to bear on him to rehabilitate him for re-entry into society. This would make of every prison a huge psychiatric hospital with enough divisions to provide all appropriate activities and segregation advantages necessary in a psychiatric hospital. Capital punishment would be abolished, not only because it is unenlightened and inhumane, and falls with grossly unequal incidence on various offenders as well as on innocent persons, but because our scientific knowledge would have advanced to the point where punishment of any kind, as such, would be recognized as ineffective. Under such an enlightened penal system (which would have to be rechristened to eliminate the connotations

of "penal") there would undoubtedly still be many criminals who responded to none of it, who cooperated with no rehabilitation attempts, and who continued to be dangerous threats to the community. These, under the indeterminate sentence, would simply remain confined—for life, if necessary, if the protection of society and their own unregenerate attitudes indicated that this was all that could be done. At least, then, every offender could look forward to something and have an incentive for cooperating with his treatment; and we would not be turning loose on society resentful, unreconstructed offenders just because their set terms had been served out. And certainly, under such a program, many offenders now caught up in the toils of the penal system after a single offense would not be sentenced or confined at all, but would be kept on probation pending the outcome of their "treatment" with a psychiatrist especially trained in dealing with this type of case.

One could presume that such proposals as these would be met with the usual outcries of "coddling", "visionary, idealistic dreaming", and "unrealistic thinking" which have been heard at every step of the way in human progress. But society is strong, and the strong can afford to be gentle and to use the power of their scientific knowledge rather than the power of their retributive punishment.

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SIDELIGHTS ON CRIMINALITY FROM PSYCHOANALYTIC PRACTICE

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In the private practice of psychoanalysis one is usually concerned with hysteria, compulsion neuroses, phobias, depressive states or borderline psychoses—the latter often with a schizophrenic coloring. The practicing psychoanalyst seldom has to deal with crimes or even minor offenses which the patient has actually committed, and even less frequently with malefactions for which he is or has been under arrest.

To be sure, patients do sometimes seek analysis for the correction of some specific defect which has brought them into conflict with the law, such as homosexuality, voyeurism, exhibitionism, kleptomania involving the stealing of unneeded and sometimes only particular articles, or a compulsion to drive past red lights in traffic. However, in the vast majority of instances in psychoanalytic practice the tendencies which are criminal occur only in fantasy or dream. Because these criminal thoughts have not involved the person in any situation realistically dangerous or threatening to him in the sense that he is liable to imprisonment or even more drastic punishment, he is more ready to discuss them freely and to lay bare for psychoanalysis the determinants entering into the formation of the criminal impulses.

Centuries before the investigations of Sigmund Freud into the unconscious psychological mechanisms of human conduct led to the development of the theory of psychic determinism and the practice of psychoanalysis, clergymen, and lawyers, and later physicians, had been deeply concerned with problems involving morality—both sin and crime. In many cases sin and crime were identical, especially in countries where the authority of state and church, the power to determine the criteria of right and wrong, were vested in one person or one group.

In the sixteenth century, with the growth of inquiry into the ecclesiastical doctrine of original sin and predestination, the question of the freedom of the will held the attention of jurists representing the state, and clergymen representing the church. If a man's will were not entirely free to control his actions, it became evident that consideration must be paid to the extent to which a given person, under particular circumstances, at a given time, might be held responsible for an offense against God and the church, called sin, or a violation against the laws of the state and the people, called crime.

In the histories of all countries, even to the present day, punishment for dissenting from the currently prevalent views in regard to a god's or God's powers and functions has been widely recorded. Rather consistently it represents the desires of the majority to strengthen their own authority, *i.e.*, by opposing and suppressing attitudes which might threaten to undermine the majority's power and security. Throughout history one finds a repetition of this phenomenon. For instance, New England was settled by persons seeking freedom from persecution because of their religious beliefs. Nevertheless, one finds these same colonists soon punishing heretics, who did not conform with their principles, by exile, imprisonment, or other penalties which were also applied to persons who violated man-made (state) laws.

The discoveries of science, such as the recognition of insanity, gradually began to undermine the righteous theocrat in his administration of punishment—especially the death sentence, such as hanging or the more savage burning at the stake of those regarded as demoniacally possessed. In later years it has altered the attitude of the state toward many violations previously treated as severe crimes, such as murder, sexual assault, alcoholism, vagabondage. Among the most notable contributions of science in changing attitudes of the law toward offenders are those of medicine, which demonstrated that in many instances of the gravest forms of crime obvious physical disabilities, such as old traumas to the head, senile dementia, epilepsy, feeble-mindedness, or very evident psy-

chotic disorders, had rendered the person irresponsible before God or to man for his anti-social acts.

One of the notable theories of Freud has to do with the development of conscience, that is, the faculty of recognizing right and wrong—those everchanging criteria which are really always determined by the presiding judge. This judge may be an individual critically surveying his own actions or an outsider representing society's conscience, passing sentence on the individual's conduct and liability. In earlier times this conscience often led him to a renunciation of religious dogma, and today constitutes the strongest force which deters most persons, children as well as adults, from perpetrating acts regarded as violations of custom or law.

Freud has pointed out repeatedly how the state and the church represent the authority which is originally invested in the individual's parents, and how the strongest ideals which a person adopts concerning the property and personal rights of others are conditioned by the attitudes of one's parents or custodians in the very early periods of life. These parental ideals of conduct gradually become incorporated into the thinking of the child and come to form what is generally known as conscience, or in Freud's terminology, his superego. The superego in psychoanalytic parlance designates that category of the mind whose function it is not only to appraise but also to regulate ego activities.

Against the ego with its culturally acquired control, the instinctual impulses of the human animal exert a continuous pressure for satisfaction. Freud has given the name of the "id" to this category of the mind which embodies primitive, savage, lawless urges. Any of these many and universal primitive impulses may be considered criminal when allowed to express themselves at certain times or under circumstances regarded as undesirable or inappropriate by a given social usage. These instinctual drives include the need for aggression, which may sometimes express itself in the form of murder, or unrestrained instinctual lust for food or sex. Among the impulses entering into sexual drives are violence (sadism), look-

ing (voyeurism), exposure (exhibitionism), etc. The sexual development of an individual may become fixed at one level, such as looking, or become over-invested with one aspect, such as violence. Sometimes several of these component impulses, such as sadism and a lack of the tender aspects of love, may find expression in a single act. This may occur as a compulsion finding an outlet in a lust murder caused merely by the sight of a nude woman of particular physical characteristics against whom the murderer has no grudge as a person.

The ego functions of the individual gradually take form through the integration of instinctive drives and those restraining forces which a person has acquired through direct instruction from his custodians or through the observation of his companions. As he grows older, these ego ideals are more firmly established through conformity to the conduct of his associates and social institutions. Against many of these latter restrictions the savage id often rebels, for the instinctual drives fundamentally wish neither attenuation nor deflection nor conversion into socially acceptable substitutes (sublimation). On the other hand, the ego, itself continually influenced by super-ego ideals (conscience), is constantly attempting to transform instinctive drives in such a fashion that they may become acceptable to it and society.

If the offense against society is really a matter of super-ego attitudes and power, it may be well to mention one of the elements which psychonanalytic theory maintains is a potent, rather universal unconscious factor influencing human conduct. It is the unconscious rivalry of the boy with his father, to mention only one side of the Oedipus (familial incestuous) conflict. The boy develops early in life a resentment against the very figure which he incorporates in his own mental structure as a model to guide his conduct. This unconscious rebellion against the father may be readily and handily directed against the social structure. Attention may be called to the relative infrequency today of parricide as compared with its importance in earlier times, indicated by this theme in drama and literature. The authority of the father is increasingly

shared by the state's laws, which now receive the brunt of youth's contempt, so that so drastic an act as father murder is no longer necessary.

Freud has taught us to study the superego (and its unconscious motivations) of those who judge as well as that of the criminal. We then see that the former have a need to punish the criminal for their own unconscious feelings of guilt concerned with their own vicious impulses which are consciously intolerable. So, too, one finds parents often punishing their children because of an unconscious animosity toward them, provoked and activated when children question the parents' absolute authority.

Criminal impulses may become acts due to inadequate superego formation, to weakness of ego integration, or to excessively strong, perhaps constitutionally determined, id strivings. In some individuals it appears as though the violent, primitive impulses had entered into a liaison with ego drives, and the desire to alter or restrict them is very slight indeed. The most important ways in which these impulses, which if unchecked lead to crime, may be satisfied are through unconscious mechanisms which Freud has called displacement, over-compensation and sublimation. By displacement is meant the shifting of a feeling from one object to another, usually with less danger resulting to the individual when the feeling is vented upon the secondary object. By over-compensation is meant the conversion of a feeling into its opposite—for example, an antagonism into over-solicitude. By sublimation is meant the conversion of some socially unacceptable impulse into a socially desirable or useful activity.

From the beginning of psychoanalytic investigation it became evident that some of these and other mechanisms were unconsciously operative and responsible for criminal offenses and anti-social conduct. The first psychoanalytic journal, the *Zentralblatt für Psychoanalyse* (1911), contains numerous references to the relationship of crime to the need for punishment, of the choice of one's profession as a sublimation for id drives, etc., and also articles, notably one by Juliusburger², indicating

the sexual factors unconsciously operative in dipsomania and in pathological wanderings and fugues. Even when not strictly psychoanalytical, since that time most studies of the psychological factors in crime take into consideration the force of unconscious, especially psychosexual, drives.

In psychoanalytic practice one daily finds examples of tendencies which, if allowed expression, would be criminal at certain times, but which are over-compensated or displaced upon objects or into situations where no danger of punishment can come to the individual. The following example illustrates:

A patient, a lawyer, aged thirty-six, married, came for treatment because of psychic impotence. The impotence proved ultimately to be dependent upon unconscious incestuous fantasies concerning his mother. He had tried intercourse on several occasions prior to his marriage but had always failed. Finally he discovered a prostitute with whom he was successful. He became greatly disturbed at his success and feared that he might be tempted to return to her. In order to protect himself against such an eventuality he notified the police that a prostitute resided at the woman's address and urged them to take action against her. He signed a fictitious name. When he observed that the police had taken no notice of his complaint after a week, he wrote a second letter. Again the police did not dispossess the woman. Finally he threatened to expose the police, and then found that the woman had been forced to move. In this manner he over-compensated for his sin and sense of guilt (crime) by becoming a crusader against vice limiting it, to be sure, only to a protection for himself.

At thirty-two he married a very pleasant and mild young woman because he thought that people might suspect him of impotency if he were not married. Again the old difficulty of impotency recurred, so that after four years the marriage had not been consummated. His feelings of resentment against his own sexual inadequacy mounted from month to month and became converted into a hatred of his wife. One day while he was under analysis he entered the bathroom while

his wife was washing her hair in the basin. Her head was bent forward exposing her neck. An overwhelming impulse arose in him to take a carving knife from a nearby kitchen table and slash her throat. When the thought came to his mind he became terrified and in over-compensation crept up behind her and kissed her gently on the neck. She was quite surprised and overwhelmed by this unwonted display of tenderness and, looking up at him fondly, said, "Thank you, dear".

So, too, one finds daily in the unconscious activity expressed in dreams the existence of hostile and criminal thoughts which the dreamer never suspected. Such a dream occurred in a patient who came for treatment because of recurrent depression for which she threatened suicide. One of the outstanding attitudes of the patient was her extraordinary affection for her older sister, which the sister seemed to reciprocate fervently. They had both married about five years previously but their mutual devotion had seriously interfered with the marital happiness of each. The patient's dream follows; in it, Doris is the sister of the dreamer and Frank is Doris' husband:

"I found myself in a large room with twin beds and a desk at which I was seated going over papers which revealed a secret plan of Doris' whereby she had established residence in a rural town in an attempt to collect Frank's insurance by proving she was a widow. When I realized what her plan was, I determined to expose her and, hearing her about to enter the room, quickly hid all the evidence. We both retired, each in adjoining twin beds, but during the night I awoke terrified to find her bending over me. Thinking she had discovered my knowledge of her duplicity and realizing she planned to kill me to prevent exposure, I cajoled her with a display of affection until she threw her arms around me, kissed me good-night and returned to her bed."

The patient continued her associations to the dream. "I had the illusion of being awake and in real danger of being murdered, although I suppose I was actually asleep and dreamed it all, and somewhere during the dream the thought

flashed through my mind that in reality I hated Doris. The next morning it occurred to me that it would have been more natural for me to tell Doris of my discovery of her plot and try to persuade her to abandon it than, as in the dream, to expose her to the authorities. This vengeful action would seem to account for the hate motif.

"The affectionate ending of the dream was, I believe, occasioned by an incident which occurred on the morning before the dream, when, in the middle of a conversation we were having, Doris interrupted me to say, quite irrelevantly, 'I don't care what your analyst says or what anyone says, you are still my baby'.

"I attributed her action to a need on her part to obliterate a feeling of separation that may have existed as a result of a short discussion we had had the night before, during which we disagreed on the significance of my disliking stuffy people. The importance of the discussion was not the subject but the tone—for it was the first time in weeks that irritation and friction were apparent in our attitudes and we both felt it.

"Although the dream was unusually realistic and although I felt very tired as a result of experiencing such an unpleasant dream and awoke slowly and with some difficulty, I found to my surprise that once I was fully awake, I could speculate objectively on the significance of the dream."

The patient who reported the dream now became conscious for the first time that the intense devotion of the sisters to each other had been developed as an over-compensation for a deep-seated rivalry and hostility of which neither was aware, that this hostility had been so great in the mind of the patient that she felt she deserved to be murdered for it, and that her sister was quite capable of doing it. With the hatred becoming conscious, and with the analysis of some of the motives which produced it, an entirely new relationship arose between the sisters where the exaggerated solicitude was replaced first by numerous quarrels but later by only normal differences of opinion. Both of them now felt free to invest their marriages,

which had been in danger of breaking up, with more love and attention.

It will be recalled that the dreamer had suffered for several years from marked depression and suicidal impulses. She desired to kill (murder) herself — an act still considered a crime under some laws and a sin by some religions. The dream tends to corroborate the psychoanalytic theory that in depression hostile impulses intended for another person, usually a near relative, are considered unworthy by the melancholic and are unconsciously directed against himself instead of the hated object. In the dream the unconscious hostility of the dreamer against her sister became expressed in a malicious wish to involve her in trouble with the law.

Instances such as this, which occur day in and day out in the practice of psychoanalysis, indicate the extent to which unconscious impulses may enter and nourish the thoughts of all human beings. The above dream introduces another element which often seems present in crime—namely, an unconscious sense of guilt which induces the individual to commit a crime in order that he may be punished. It seems not unlikely that the unconscious hatred against Doris of which the patient was guilty may have induced her to dream of doing something ethically quite questionable against her sister, and this in turn may have been responsible for the threat of a dire punishment—namely, death at her sister's hands: that is, the wages of sin are death.

Even self-punishment may at times appear in sleep, as in the case of a patient, married, aged forty-six, who felt intensely guilty concerning her masturbation which she had continued from childhood straight through her married life for more than twenty years. This made her frigid with her husband, but she had learned to simulate orgasm perfectly. She suffered from many terrifying, sexual tinged dreams, but one of the most interesting features in her case was that during her sleep she would pinch and bruise her body, as though through this activity she satisfied the need for punishment because of her duplicity.

To be sure, many of these unconscious criminal tendencies which are severely suppressed by society cannot be sufficiently attenuated or sublimated by some people. They do not continue as day dreams, dreams, fantasies, or as thoughts which flash to the surface of consciousness and there vanish through their exposure. Under sufficient provocation, or with a lowering of the threshold of suppression or repression, they may be transmitted into actions representing a protest against authority. Nevertheless, one finds that under treatment such neurotically invested impulses can be adjusted and replaced. I should like to refer to a case of this type observed by me seven years ago³.

The patient, aged twenty-one, suffered from a compulsion "to be where he was not"—*i.e.*, to be at home when he was at college, and vice versa. The compulsion had become so strong that it interfered with his completing almost any duty. But he also suffered from voyeurism, for which he was arrested at the age of twenty-two. He was saved from a jail sentence through the interference of the local political boss who arranged devious manipulations of the legal process. This arrest and the threatened imprisonment, however, did not deter the patient from subsequent escapades in voyeurism, during which he again came in contact with the law; on one occasion he escaped by bribing the detective. The voyeurism in this case unquestionably represented a defiance of the patient's rigid, moralistic parents and a sexual satisfaction through a regression to an infantile component of sex, peeping, rather than adult sexuality, which he thought his parents would condemn. When the patient could be brought through analysis to the acceptance of heterosexuality by the resolution of his fear of woman, he abandoned voyeurism and has been successfully married for several years.

As already indicated, the study through psychoanalysis has disclosed how the psychology of the neurotic mirrors that of the criminal. A neurosis unconsciously gratifies, usually in a negated (and disguised) form, perversions and wishes which are not acceptable (are indeed often criminal) to the individual's own standards or those of his environment. Fur-

thermore, the neurotic suffers great mental distress, that is, is punished (punishes himself) for indulgence of his disapproved thoughts. This sequence of events occurs with many neurotically inclined criminals, and quite often can be traced in their crimes almost as a compulsive repetition. They do something which they ardently wish, in spite of the fact that they know they are likely to be punished, and seem to prefer the realistic punishment administered by the law to the endless suffering endured through their guilt and anxiety.

The study of the unconscious motives behind criminal acts in the light of the revelations of clinical psychoanalytic practices would seem to offer a new implement for the cure of crime. However, the cure of most neuroses is long and stubborn, because the neurotic has developed an urgent need for the unconscious protection or gain which his illness yields him. So, too, the need of the criminal to vent his hostility against society because of repressed aggression or a projection of his sense of guilt is forceful and recurrent, and is apt to form a vicious circle. In some cases, the union of the primitive urges with the policing faculties has become so complete that little conscious desire exists to change unlawful activities.

Hence, the discoveries of psychoanalysis are perhaps more valuable in understanding the drives of most criminals than in curing them. But it is this understanding, due largely to the work of Aichhorn¹, which is now being applied to conduct deviations of the young, as delinquency, wandering, arson, etc., in the hope of prophylaxis of psychoanalytically influenced thought, which is becoming more and more widespread, may also account for the changes which are operative in the approach of progressive jurists in cases which they are called upon to decide, from relatively minor offenses—such as exhibitionism—to murder, in which the ordinary motives of revenge or loot are not apparent or may be unconsciously displaced.

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